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EDITORIAL

GEORGE H. YEAGER, M.D.*

Through the efforts of Dr. Harry F. Klinefelter, Jr., and with the endorsement of Dr. Harold B. Plummer, the immediate past president of the Maryland Academy of General Practice, a series of articles will be published in this JOURNAL, designed to present current specialized knowledge in an easily assimilated manner. Each article is being presented by an authority recognized in his respective field.

It is realized that the average practitioner does not have either the time or inclination to read and study current literature, particularly if it contains obscure figures and confusing statistics. New drugs and new modes of therapy are being developed so rapidly that stability with reference to their usage becomes difficult. Concepts that are acceptable today frequently become unacceptable tomorrow.

Today the thinking of the entire medical profession is toward better education of all its members. The development of the American Academy of General Practice has focused additional attention upon the necessity and need of graduate level information for the general practitioner, with emphasis upon current trends. The chartering of the Maryland Academy of General Practice by the American Academy of General Practice has emphasized such need at the local level. It is hoped that the present series of articles will prove to be a worthwhile contribution toward that need.

* Editor, Maryland State Medical Journal and President-elect, Medical and Chirurgical Faculty.

Scientific Papers

Chest Diseases in General Practice

WARDE B. ALLAN, M.D., F.A.C.P.*

In the past few years there has been an increase in the number of patients with lung changes that present a problem for the general practitioner in his office practice. This increase has been due, in part at least, to the availability of x-ray facilities. The mobile units and routine chest x-ray surveys are ever increasing their scope. The method of reporting the findings to the family doctor is commendable. In the cases in which positive findings are reported the intelligent follow up by the physician is of vital importance. Many positive reports need not be pursued further because the lesion may be one of long standing and stable. However, in all other cases a large or regular 14 x 17 film should be requested. A lateral film is also of importance because the lesion usually can be located more accurately. In many cases this information alone will permit an accurate diagnosis. Other x-ray procedures may be employed, the most revealing being bronchograms and laminograms.

Chest diseases in general practice usually fall into one of several groups. Though all pulmonary lesions cannot be covered, the important ones will be outlined.

The common bacterial infections of the bronchi and the lungs are seen more commonly now in general practice than in hospital practice. Acute bronchitis and the pneumonias can be handled adequately in the home except when complications arise. At this point a word of warning is definitely in order. It is unwise to prescribe sulfonamides or antibiotics or a combination of these indiscriminately just because

the patient has fever. We must appreciate that these therapeutic measures are life saving but it has been recognized that resistant strains of organisms have developed. This serious state of affairs can be blamed on indiscriminate and inadequate drug therapy.

Bronchiectasis is a common condition that requires careful evaluation before therapy is instituted. The history of a chronic cough, copious sputum and hemoptysis is a well known triad of symptoms. However, all such cases are not due to bronchiectasis. As a rule, the usual x-rays of the chest fail to confirm or disprove the presence of marked or minimal ectasia. Where this condition is suspected three important steps are essential. First, sputum examinations and cultures are made. Sensitivity studies of the isolated organisms to the various antibiotics should be requested. Second, bronchoscopy by a competent and experienced operator should be done and third, bronchograms are then requested. All branches of the bronchial tree should be visualized before any definite therapy is advised.

The only procedure by which a "cure" can be accomplished is to have the involved segments or lobes removed by operative means. This procedure is one which should be done only by qualified chest surgeons.

Many cases of bronchiectasis cannot be submitted to surgery, namely in patients with extensive disease and in the older patients. These cases are often challenging problems. General medical procedures can relieve these sufferers. Postural drainage, properly taught and performed to get good results in the production of sputum, is an invaluable aid. If this procedure is

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done in the morning and evening it will give the patient better days and nights. The use of bronchial dilators (Isuprel, 1:200) in a nebulizer before drainage is most helpful. The addition of Alevaire has proven useful in liquifying the secretions and promoting better drainage. In addition to these measures, it is often helpful to have these patients on prophylactic sulfonamides or one of the antibiotics through the winter months. This has reduced the incidence of pulmonary complications which commonly follow upper respiratory tract infections.

Tuberculosis is a disease that should be recognized by physicians in general practice. When a suspicious lesion is found, it is the duty of the practitioner to ascertain whether or not tubercle bacilli are present. A three day collection of sputum in a sterile glass jar can be used for smear and culture. The physician can be helped by one of the several private laboratories in the state. The facilities of the city and state health department laboratories are also available. These laboratories can also do gastric washings for the identification of tubercle bacilli. Once a diagnosis has been established it is most important to institute therapy. As a general rule it is unwise for anyone not skilled in the intricacies of tuberculosis to embark on a prolonged course of treatment for that disease. It is our opinion that such therapy should be under the direction of someone who devotes the majority of his time to such a practice.

As we have mentioned, the miniature films have brought to light solitary asymptomatic lesions of the lungs, so-called "coin lesions." From the statistics it is known that an alarming percentage of these are malignant. For that reason all such lesions should be resected. The possible exception to such a radical procedure is in those instances where the "coin lesion" contains calcium. Many observers believe that this type of lesion, known as a tuberculoma, is likewise a potential hazard to the patient and should be removed. Solitary tumors of this type

are removed by a wedge resection, segmental resection or lobectomy.

Cancer of the lung by all statistics is on the increase, a very real increase rather than due to the fact that it is more easily recognized. It is unfortunate that this condition is not always recognized early. Pneumonectomy is the only treatment that has brought about a "cure." The results are, on the whole, not too gratifying. However, even in most instances, it is advisable to perform a thoracotomy. If the tumor is classified as inoperable, palliative procedures have proven most helpful. X-ray therapy as an adjunct to surgery is always worth consideration. Radiation therapy has proven valuable in cases of superior sulcus tumors and has given relief from the pains of local invasion and metastases. The newer drugs have been tried and of these the nitrogen mustards are the best. The mustards frequently control cough, chest pain and bone pain.

It is urged that all lung lesions be quickly evaluated and be placed in the hands of those people best able to treat such cases either by medical means or by surgical procedures.

One of the most disabling of pulmonary diseases is emphysema. The causes and mechanisms are not clearly understood. The respiratory distress in the condition is progressive and crippling. In the treatment of this condition broncho dilators, respiratory exercises and positive pressure oxygen have proven to be of considerable value.

Finally, it is important to know when to take an x-ray of the chest. It is not always possible to obtain an x-ray of the chest as a part of a routine physical examination. It may add a financial burden to any given patient. However, x-rays of the chest should be taken if the patient has a persistent cough, or has noticed even a fleck of blood in the sputum after coughing. Dull aching pain in the chest or pain in the shoulder and arm are very strong indications for such a study and x-rays should also be taken in all cases of acute

pulmonary infections after recovery from the acute episode. In conclusion, it is urged that all patients with pulmonary disease be carefully studied. Specific treatment of any pulmonary

lesion should not be instituted until a definite diagnosis has been established.

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AMA TESTIFIES ON HEALTH BILLS BEFORE SENATE SUBCOMMITTEE

The AMA Washington Letter, No. 67

Dr. David B. Allman, chairman of the AMA's Committee on Legislation, on April 13 testified before the Senate Labor and Welfare Committee's Health Subcommittee on four of the major health bills proposed by the Eisenhower administration. "In general, we agree with the stated purposes of these proposals," Dr. Allman said, "but we believe that considerable more study is necessary to determine the most desirable ways to accomplish these objectives." Following is a summary of Dr. Allman's testimony on each of the bills:

Public Health Grants (S. 2778). The bill proposes that the present grants for designated diseases be eliminated in favor of three new types of grants, (a) for public health services in general, (b) for extension and improvement of service, and (c) for "unique projects," or pilot operations. Dr. Allman recommended that the proposed new type one and two grants be lumped together, with the state public health officer using the funds as he sees fit, and that the Public Health Service surgeon general be required to consult with state health authorities or an advisory committee before allocating money for type three projects, which could be given to private as well as public projects. He also recommended that "only a small percentage of funds" be earmarked for type three grants.

Hill-Burton Expansion (S. 2748 and H.R. 8149). Dr. Allman suggested that the Senate bill be amended to include a declaration of purpose similar to that in the House-passed measure, reaffirming that installations are for use of the entire community. He also called for a clarification of the relationship between priorities in the present act and those in the proposed measure, and for more specific definitions. He declared: "In particular the definition of 'diagnostic or treatment centers' is vague and ambiguous. It is not clear whether 'a diagnostic or treatment center' will include an individual physician's office, a group clinic, operated by physicians, or any hospital. How will the inventory be made by states under vague terminology of this type? We consider the language of this part of the bill to be an unwise amendment to an act which has been highly successful to date."

Vocational Rehabilitation (S. 2759). The bill would change the method of making grants to states in the interest of better administration. Dr. Allman told the committee that the Association "has not received a sufficiently clear explanation" to permit formation of a final opinion on the bill. He said AMA "has no position on the proposal at this time."

Reinsurance (S. 3114). Dr. Allman gave complete indorsement to the stated purpose of the bill, to promote the best possible medical care on reasonable terms. This, he said, has also been an objective of the AMA. Dr. Allman recounted progress of voluntary health insurance, then said he thought the future holds real promise for still greater progress. He concluded: "It is the belief of the American Medical Association that the bill will not fulfill its intended purpose and may, in fact, inhibit the satisfactory progress which is now being made by voluntary insurance companies."

Obstetrics in General Practice

LOUIS H. DOUGLASS, M.D.* AND D. FRANK KALTREIDER, M.D.†

Today the large majority of all births in urban and many in rural areas occur in hospitals and rightly so. Hospital deliveries are more convenient for both patient and physician and are certainly much safer. This trend is in some measure responsible for the very gratifying lowering of maternal mortality of recent years. Of more importance, however, is the attitude of the practicing physician who is always striving to do better and better work and to avail himself of advancements in medicine generally.

The very probable reason why so many men in general practice include obstetrics is because of a real liking for, and deep interest in, this branch of medicine. And it is certainly true that if this liking and interest exist, the physicians should continue to include obstetrics in their general practice. On the other hand, should it become an unpleasant burden, then, in fairness to himself and to his patients, the physician should cease to do obstetrics and should confine his work to those fields which are more pleasant for him.

For the physician in a general practice which does include obstetrics the general rules of the practice of medicine should apply, together with a few special ones.

First, it should be remembered that the process of reproduction is a normal, physiological function and, in the majority of instances proceeds most smoothly, when there is no ill advised interference. While keeping this in mind, it should also be realized that the dividing line between normal and pathological is a very fine one indeed; a line which may be crossed very easily and at times with startling abruptness. Therefore, there must be constant vigilance, early recognition of the slightest deviation from normal and prompt and proper treatment.

A long experience with maternal mortality

studies in the counties of Maryland has proven that almost without exception the physicians of our State are greatly interested in doing the best possible work. They have cooperated wonderfully in the study of those deaths which have occurred, they have accepted criticism most graciously and, most important of all, they seem to have profited by their mistakes. These men richly deserve all the acclaim and respect we can give them.

Also as a result of this same study a few deficiencies seem to stand out and these should be mentioned:

1—In a number of the reports of maternal deaths the physician stated that "The patient failed to cooperate and did not follow instructions." Would it not have been nearer the truth to have said "The physician failed to cooperate and did not impress upon the patient the necessity of following instructions"? Most people are vitally interested in themselves and are willing to do what they are convinced is for their own good. But they have to be convinced first, convinced that the doctor is interested in them and that his instructions are important for the good of the patient. They must be concise, clearly understood and often the reason for them must be explained. What is meant may be illustrated by the following condensed case history, an actual case:

A multigravida, known hypertensive with cardiac involvement, reported to her physician for prenatal care at about the 24th week. Her blood pressure was 180/120 and the urine contained albumen. Patient was placed on a low salt diet and told to return in *three* weeks. She failed to report until six weeks had passed and her condition had worsened; she was given another appointment which she also failed to keep until another six weeks had passed. Advised to enter the hospital. Refused. Allowed to return to her home and not seen for four weeks when her husband called and stated patient was having convulsions. Admitted to the hospital but

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consultation was not requested until six hours after admission. Active and proper treatment now given. Too late. Patient died about twenty hours after arriving at hospital.

It should be evident to everyone that this patient should have been hospitalized at her first prenatal visit for evaluation and treatment. It is quite possible that 15 or 20 minutes spent in explaining to her the dangers involved and the necessity for a complete study would have convinced her and made her willing to "cooperate." When she failed to return upon the specified date, she should have been contacted at once and if she still refused to report the physician had 2 choices:

a—He could have gone to see her and

b—He could have retired from the case.

One of these 2 courses should have been followed. As long as he continued to be responsible for the patient it was his duty to treat her properly, even though at a great deal of personal inconvenience. The remainder of this case history speaks for itself as an example of mismanagement.

2—Another frequent contributory factor to maternal mortality would appear to be an incomplete evaluation and treatment of some of the more common medical complications of pregnancy. A number of reports have been received of patients dying of heart disease complicated by a pregnancy and in almost every one of them it is evident that no attempt was made to evaluate the status of the heart early in pregnancy. The patient was seen too infrequently and little or no treatment was given until frank decompensation appeared. The same is true of many other complications.

3—Hesitancy in seeking consultation. Why this should be is difficult to understand. Is the general practitioner so much of a "lone wolf" that he feels competent to care for any emergency or complication? This is almost certainly not true. Does he hesitate to seek aid for fear his patient will lost confidence in him? If this be true he is jeopardizing the life of the patient for the sake of his pride and he also is working on a

false premise. Patients appreciate the doctor who is honest enough to admit his limitations and to seek help. Waiting until the patient's condition is desperate before obtaining consultation is a poor policy indeed.

With these exceptions, which are somewhat isolated instances, it would appear that the physician in general practice in Maryland is doing an excellent job in obstetrics. He must continue to realize his limitations and must be ready to seek advice and help when there occurs some deviation from normal.

The hospitals of the State must recognize their responsibility in this matter and must be in a position to grant privileges and also to vary the scope of these privileges to fit the ability of the individual physician. Consultation must be available and must not be too much of a financial burden upon the patient. Indeed in many instances, consultation will have to be furnished without remuneration.

It must be the duty of the medical school and the teaching hospital to teach and train the student and intern in the fundamentals of sound, conservative obstetrics and the early recognition of abnormalities and complications. The necessity of consultation must be stressed during this formative period and its advantages demonstrated.

Taking everything into consideration it is felt that obstetrical care in this State is on a very high level and is constantly improving. Naturally there is room for more improvement and it is doubtful that any of us will ever reach perfection. It would be unfortunate if we did for if there is no improvement to be attained, the incentive to work disappears and monotony and boredom occur.

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Topical Treatment of Dermatitis or Eczema

A REVIEW OF SIMPLE PRINCIPLES

H. HANFORD HOPKINS, M.D.*

Under the general classification of dermatitis or eczema there may be grouped more than one-half the Dermatological problems encountered by the physician. Regardless of the cause, whether external or internal, the condition is characterized by erythema, blistering to a greater or lesser degree, subsequent scaling or crusting, and itching. The general principles of topical treatment are more or less the same for the entire group. Since doctors in general are daily bombarded with samples of new salves, lotions, washes, soaps, detergents, pomades, etc., each supposed to be the "sine qua non" in its field, we often become confused, and forget basic treatment principles, often to the detriment of the individual patient.

Common examples of clinical dermatitis or eczema are Poison Ivy, Seborrhoea or Atopic Eczema in their many locations and forms, pruritus of the anus and vulva with associated eczematous changes, dermatitis or eczema of the hands and feet. Although Epidermaphytosis, (Athlete's Foot), is a fungus disease it presents the subjective and objective picture of dermatitis or eczema, and should be so treated, with specific modification indicated by specific etiology.

The first and cardinal principle of topical treatment for this group of diseases is to bring to the patient as much comfort and relief from suffering as possible, and at the same time *do him no harm*. This should mean disregarding the new and wonderful salve which came in the mail today, and sticking to the tried and known remedies of yesterday. It is very easy to make an eruption worse, and this is often inadvertently

done by the application of remedies which are new and relatively untried.

For purposes of topical treatment, all cases of dermatitis or eczema should be first classified in the mind of the attending physician as acute, sub-acute, or chronic. Let the acute category contain all patients who show swelling, redness, blistering, moist crusting and weeping. These are the acute "wet cases," and for them one specific set of rules of treatment should apply. Let the chronic category contain all cases who show little or no swelling, little redness, no blistering, but only thickening of the skin, scaling and cracking. These are the chronic, or "dry cases," and for them another set of rules should apply. Between the acute "wet cases" on the one extreme, and the chronic "dry cases" on the other, there exist all gradations between acuteness and chronicity, and this, of course, is the sub-acute category. It too has its special rules of treatment.

Although some patients first come to the doctor in the early phase of their eczema or dermatitis, others treat themselves with home or drug store remedies which may worsen the disease and occasionally cause it to become generalized due to a drug allergy. In most patients with dermatitis or eczema, the disease goes through all three phases, some slowly, and some rapidly. In each, one phase is dominant for a longer period of time than the others, and thus often becomes the presenting picture when the patient applies for help.

To consider the different principles of treatment for the acute, sub-acute and chronic categories of dermatitis or eczema Poison Ivy may be taken as an example. The patient with a severe attack of this disease usually begins with a

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typical acute or "wet phase," passes through a sub-acute phase, and recovers after a relatively short chronic or "dry phase." Plans of topical treatment which are applicable to the three phases of Poison Ivy Dermatitis are also in general applicable to the three phases in any dermatitis or eczema.

The acute or wet stage of Poison Ivy should have wet treatment. Wet treatment consists of the use of baths or compresses. The extent and distribution of the eruption determines whether one prescribes baths or compresses. For attacks involving a large part of the body surface, baths are preferable, and for those which are localized, compresses. The purpose of both forms of treatment is the same, namely to comfort the patient and keep him clean. Whether it be baths or compresses which are chosen, they should be used often enough, and long enough, to keep the patient as comfortable and clean as possible without the production of maceration of the skin from excessively prolonged wetness. The temperature of the bath or compress should be comfortably warm in winter, and pleasantly cool in summer. The simplest and safest bath for home use is the oatmeal bath. It is made by cooking one or more cups of oatmeal, placing the cooked oatmeal in a salt bag or cheese cloth bag, and swishing or squeezing the bag of oatmeal in the tub of water until the water is milky white. When the patient removes himself from such a bath he should pat and not rub the skin dry. Medicated baths should be avoided and left for the experts. Probably the best solution to use for compresses in the home is the saturated solution of boric acid. Physiological sodium chloride solution is very safe from the standpoint of being non-irritating but is more apt to allow the development of secondary bacterial infection. Boric acid solution should be made and used in large quantity. The ten quart water bucket, used in almost every home is ideal. The patient or nurse is instructed to dissolve ten level tablespoons of boric acid powder in the bucket full of

water. This is done most easily by making a soft paste of the measured powder with hot water in a cup and stirring the paste in the bucket of water until it is completely dissolved. Compresses should be bulky and applied sopping, but not dripping wet. They should be applied as a pack, and not wrapped around. An old soft Turkish towel is excellent. Compresses should be kept sopping wet by redipping them in the bucket of solution. They should not be allowed to dry in place because the boric acid crystallizes out and becomes irritating; and should not be remoistened by pouring on more, for the same reason. When compresses are removed, the affected parts should be allowed to dry in the open air if possible, and should not be bandaged.

When the acute, wet phase of the attack of Poison Ivy Dermatitis subsides into the drier, sub-acute stage, the use of wet treatment is gradually diminished in frequency and duration. The patient then needs interim treatment between the baths or compresses. For this purpose there is nothing better than powder either as such, or suspended in a liquid. The simplest and cheapest powder is cornstarch. It should be dusted on profusely between the baths or compresses. Calamine lotion, either with or without one percent phenol is still the safest lotion. Avoid lotions which contain antihistamines. They have no special virtue, sometimes sensitize the skin and produce dermatitis. Calamine lotion should be applied with the bare hand or a clean paint brush. Absorbent cotton or gauze should not be used since it removes the powder from the lotion. As the patient passes through the sub-acute phase the lesions become drier and drier, wet treatment is gradually minimized, and gives way to more and more powder dustings or applications of lotion. It is important not to begin the use of powder or lotion too soon since when applied to an exuding surface it forms an adherent cake which is uncomfortable, and under which infection may develop.

The chronic or end stage of Poison Ivy Derma-

titis is comparatively short. It is characterized by dryness, scaling, and desquamation, partly the result of the disease and partly the result of baths, compresses, lotions and powders. It demands only the use of a simple emollient, such as cold cream, vaseline, or light mineral oil until the skin has returned to normal.

Any case of dermatitis or eczema, acute, sub-acute, or chronic, can be safely treated by following the above rules. No patient will be made worse by such treatment. Many patients fully recover on just such simple measures. Expert advice should be sought for those who do not. If the physician will emphasize to the patient that most attacks of dermatitis or eczema are measured in weeks and not days, and that there are few short cuts in topical therapy, then fewer complications will arise as a result of injudicious therapy.

Certain precautions having to do with the use of wet, dry, and emollient treatment are necessary. It has already been pointed out that if baths or compresses are excessively used, maceration of the skin and even sloughing can result. This is especially apt to occur in intertriginous areas, notably between the toes, and the buttocks. Such opposing or enclosed skin surfaces should be carefully and completely dried after each bath or compress, before powder or lotion is applied. Oils, greases, and ointments should never be applied to the acute phase of dermatitis or eczema, except at times perhaps for the specific purpose of controlling or overcoming secondary infection. In general they increase discomfort, hold in the exudate and prolong recovery. Oils, greases and ointments furthermore are often badly tolerated on intertriginous areas. Applied between the folds of the buttocks, perineum, breasts and axillae, they often cause maceration, or a troublesome folliculitis. The use of soap and water is an important consideration in dermatitis or eczema. It is common practice to completely forbid the use of soap and water in all cases. Although this complete prohibition

is of benefit to some cases, notably dermatitis or eczema of the hands which often is caused in housewives largely by the excessive use of soap and water, it is unnecessary in many others. Soap and water is actually beneficial in some cases. Many cases of pruritus of the anus or vulva, with mild secondary or associated dermatitis or eczema, will improve or actually recover if the creases are washed carefully with a mild soap and water, dried thoroughly, and dusted with bland powder after each defecation.

In the treatment of the sub-acute and chronic eczemas and dermatitis, the number and variety of ointments available to the practitioner are almost endless. This is true also of the antiseptic, bactericidal, antibiotic, and antipruritic solutions. He would do well to avoid the use of all those preparations with whose effects he is not thoroughly familiar. When a chronic dermatitis or eczema does not respond to simple and well evaluated remedies of this type, he does well who then considers the condition a "noli me tangere," and calls for experienced help and counsel. It is well to remember that Calamine liniment (Calamine lotion in which olive oil has been emulsified), is an excellent and safe remedy for dermatitis or eczema in its uncomplicated sub-acute state, and similarly plain Lassar's paste is very useful and safe when applied thickly over an eczematized extremity and bandaged. Phenol should not be incorporated in paste or ointments which are covered with bandages because of the danger of systemic absorption and poisoning. In treating chronic eczema or dermatitis which is extremely itchy the practitioner often turns to stronger and more varied antipruritics, because of the rebelliousness of the problem, and thereby becomes confronted with an eruption which becomes worse instead of better. It is a problem easier to avoid than to combat after it has once developed. The simplest of remedies are usually the best except in the hands of the most experienced.

This review should not be construed as a diversion from the importance of definitive diagnosis in the individual case of dermatitis or eczema. Definitive diagnosis often spells the difference between success and failure in treat-

ment, but diagnosis does not lie within the province of this paper. The sole stress is upon general principles of topical treatment.

1201 North Calvert Street
Baltimore 2, Maryland

* * * *

MEDICAL STAFF NEEDED FOR SUMMER MONTHS

Camp Louise for girls and Camp Airy for boys, situated in the Blue Ridge Mountains of Maryland have vacancies for a medical staff. Third year medical students are acceptable. They can also place several nurses.

If interested call Miss Ida Sharogrodsky at the Baltimore office—641 North Eutaw Street, Saratoga 7-4828

PROCEDURE SET FOR DOCTOR DRAFT LOYALTY CASES

The AMA Washington Letter, No. 65

In anticipation of passage of the amendment to the Doctor Draft act, Defense Secretary Wilson has established a policy for handling all suspected loyalty cases arising under the act. (The amendment would permit the Armed Forces to retain, in noncommissioned status but assigned to professional duties, any physician, dentist, or veterinarian whose loyalty is questioned.) If the amendment is enacted, the following procedure immediately will become effective: (1) If questions of loyalty interfere with commissioning, an "intensive investigation" will be conducted; a 90-day limit is placed on the investigation, except in unusual cases, (2) if the man is found to be a security risk he will be "expeditiously processed out of service with an appropriate discharge," which will state that he was discharged *because his retention was not consistent with the security of the United States*, (3) if investigation clears the man, he will be offered a commission at the appropriate rank, (4) during the investigation, the individuals concerned will be "retained in an enlisted status and used in their professional capacity under necessary safeguards."

The proposed procedure was outlined by Assistant Defense Secretary Hannah before the Senate Armed Services Committee just before it reported out the Doctor Draft amendment.

Allergy in General Practice

JOHN W. PARSONS, M.D.

The manifestations of allergy constitute such a widespread and varied group of symptoms that every physician is likely to encounter some expression of the allergic state from time to time. It is variously estimated that ten to twenty-five per cent of our population have inherited the capacity to develop hypersensitivity to substances met in the environment, the so-called "atopic" reactions. There is no hereditary limitation on the ability to develop hypersensitivity to substances elaborated within the body, the "intrinsic" allergic states.

The latter category includes most of the sufferers from those allergic disorders which appear in the latter half of the life span, chiefly the asthmatic bronchitis and chronic urticaria appearing after the age of forty, and also many of the chronic cutaneous lesions of later life. A search for specific exciting factors is usually unavailing. This group of disorders is frequently associated with infections but in many cases no infectious process may be demonstrated, nor do presently known diagnostic methods give clear-cut evidence of the infective nature of the disorder. There is ample proof that concomitant infection leads to aggravation of the disease processes and control of infection is frequently followed by gratifying alleviation of symptoms. Emotional factors play an important part in this group of diseases, so much so that many cases of asthma, dermatitis, and other expressions of allergy are said to be wholly on the basis of emotional imbalance.

The atopic disorders usually appear at an earlier age, frequently are found to be associated with a positive family history of similar reactions, and are found to be caused by substances originating outside the body. The offending agent may be detected by history, by skin testing, or by challenging the patient with suspected offending materials. Thus, a history of respiratory symp-

toms occurring in August and September indicates probable ragweed pollen sensitivity; a history of frequent headaches or constipation may lead to disclosure of use of drugs to which sensitivity may have developed. Skin testing is of value in confirming facts of the history; it is particularly useful in detecting hypersensitivity to contributory factors and in determining the probable offending agents in those cases where the history is not revealing. The provocation of symptoms by feeding a suspected food, introducing a small amount of a suspected substance into the nose or conjunctival sac, or applying likely materials to the skin under adhesive patches is a useful means of determining the cause of allergic disorders. Infectious processes and emotional factors here, as in the case of the "intrinsic" allergic disorders, play an important contributory role in the aggravation and prolongation of symptoms. Either of these, together with physical agents such as chilling, overheating, or exposure to sunlight may act as triggers in initiating symptoms that had been in abeyance.

There is a common physiological mechanism in all the allergic states as indicated by the universal finding of edema (with concomitant muscle spasm in the bronchi and with eosinophilia) at the site of reaction be it in the skin, the respiratory mucosa, the conjunctiva, or the alimentary canal. Certain headaches are probably due to edema induced by a blood borne allergen. The edematous reaction is thought to be produced by liberation of histamine, or a similar substance, at the site of reaction between cell-bound antibody (reagin), and antigen (allergen), directly applied or blood borne. Many such reactions may be prevented by "antihistaminic" drugs which block the action of histamine. The topical or systemic application of epinephrine and other sympathomimetic drugs results in

reversal of this process. Further evidence of the unitarian nature of these disorders is their response to the adrenocortical hormones, whether administered in the form of the steroids or excited to production by the corticotropin of the pituitary.

Preventive treatment of the allergic disorders varies with the type and tissue involved. Where the offending substance is known, the patient may be able to avoid it; thus, the removal of a dog or cat from the home may result in complete relief of rhinitis or asthma, substitution of rubber foam for feather pillows will be helpful to the feather sensitive patient, and abstinence from foods proven to be offenders may make further treatment unnecessary. However, there are many individuals whose symptoms are produced by multiple factors, some of which, such as airborne pollens, house dust and fungus spores cannot practicably be excluded from the environment. Altering the patient's response to such factors by the hyposensitization (commonly spoken of as "desensitization") method will frequently result in gratifying control of the condition. Failure to obtain good response to the hyposensitization procedure is usually due to one or more of several factors such as insufficient dosage, failure to recognize and apply treatment against the full range of offending agents, persistent infectious processes, or unresolved emotional problems.

Treatment of the active symptoms calls for recognition of various physiological and anatomical derangements. Uncomplicated acute urticaria and its counterparts, allergic conjunctivitis and rhinitis, may be relieved promptly and suppressed indefinitely by use of antihistaminic drugs. These agents are, however, disappointing in the treatment of the more severe disorders such as asthma or atopic dermatoses. Epinephrine, 1:1000 aqueous, in doses of 0.3 Ml., subcutaneously, for immediate effect, and 1.0 Ml. of the 1:500 suspension in oil intramuscularly, for prolonged effect, is the basic remedial agent in these conditions. Applied

topically to the conjunctiva and nasal mucous membrane and by nebulization of the 1:100 solution for relief of asthma, this hormone has been of inestimable value. Ephedrine, for its convenience of oral administration, is less prompt and somewhat less effective than epinephrine. Synthetic drugs simulating these natural agents chemically and pharmacologically have value but, in general, are less effective.

Asthmatic breathing, usually thought of as an expression of allergy, may be produced by other mechanisms such as congestive failure, pulmonary fibrosis, tumors or bronchial infection. This state, whatever its etiology, is associated with bronchial obstruction in which muscle spasm, accumulation of tenacious secretion, and mucosal edema play a part. Aminophyllin and theophyllin preparations are of great value in relieving the spasm of the bronchiolar muscle. The intravenous or rectal administration of aminophyllin is usually demanded, as the dosage, 250 to 500 mgm., needed to produce a satisfactory effect is not well tolerated by mouth. Given in combination with ephedrine and a barbiturate, these drugs are of some value in oral doses up to 0.2 gm.

Potassium iodide is the most useful agent in bringing about liquefaction of the plugs of mucus which form in the small bronchi in asthmatic states. Usually well tolerated, it may be given in combination with antispasmodic and expectorant drugs. It must be noted that inspissated mucus in the bronchi cannot be liquified unless the general state of body hydration is satisfactory. Long continuing asthma may lead to pronounced dehydration. Other salts of iodine may be useful in this regard where the potassium salt is not well tolerated.

Bronchial infection, frequently associated with upper respiratory tract infection, is almost always found in asthma of long duration, and often it is the primary cause of disease. Chemo-therapeutic and antibiotic control of the infectious element, based, where practical, on cultural studies must be obtained in order to

attain relief of the symptoms. Broad spectrum antibiotics are, in the event that specific sensitivity tests are unobtainable, of great value in this regard. Eradication of suppurative foci is essential in order to obtain lasting relief.

Adrenocortical hormone therapy, soon to be described in considerable detail in this Journal, has opened a new and enormously effective therapeutic approach to treatment of the allergic disorders. The reader is referred to the report of the Baltimore City Medical Society panel discussion for details as to dosage and supervision of the effects of this type of therapy. It is noted that the cortical steroids, cortisone and hydrocortisone, through a little understood action, bring about a reversal of practically all the allergic phenomena. The response to infection on the other hand, an inflammatory reaction leading to repair by fibrosis, may be dangerously affected by the steroids through their depression of fibroblastosis. Thus, dissemination of infection may follow therapy intended to control an allergic state in which bacterial invasion had not been suspected. Such bacterial infection should, therefore, be sought before and during treatment with the hormones and, if found to exist, should be countered by the concurrent administration of antibacterial drugs such as sulfonamides or antibiotics as indicated by cultures and sensitivity tests.

Combined hormone and antibacterial therapy is usually indicated in asthma of long standing, the antibiotic or sulfonamide being discontinued when physical signs and laboratory procedures indicate eradication of the infection. In this connection, it is of interest to note that the fibrolytic property of the steroids is utilized to break down, in some degree, the protective barrier around an infective lesion in order to permit more intimate access of antibiotics to the site of bacterial growth. This mechanism is of considerable value in the treatment of nasal polyposis. It is, obviously, to be pursued only with strict supervision of the patient to guard against spread of infection. Activation of

quiescent tuberculous lesions has been observed in this type of therapy, an event fraught with danger but probably controllable with streptomycin in combination with other anti-tuberculous drugs. Perforation of peptic ulcer has occurred occasionally, making it imperative to administer antacid therapy along with the hormone where such a lesion may possibly exist. Demineralization of bone leading to osteoporosis of such degree as to result in collapse of vertebral bodies may come about in prolonged therapy. In this event, it is probably of no avail to feed supplementary calcium or Vitamin D.

Bearing in mind that cortisone, hydrocortisone and corticotropin (ACTH) serve only to suppress the functional manifestations of allergy, not, as is repeatedly stressed, to cure the allergic state, the physician is properly advised to administer these agents where other means have failed to bring relief to the patient. Prompt and persistent treatment may be lifesaving in status asthmaticus, severe drug reactions, and overwhelming infections with shock. Dosage must be in effective quantity, repeated as often as necessary to bring about and maintain control of the symptoms. Thus, in severe asthma intravenous administration of forty units of ACTH in a liter of five per cent glucose solution may be given in the first eight hours. Forty units of the ACTH gelatin suspension, intramuscularly, at twelve hour intervals may be used in less severe cases. Cortisone, two-to-three hundred milligrams, or hydrocortisone, one-to-two hundred milligrams, in divided doses daily will usually be sufficient to attain control of asthma, severe rhinitis, with or without polyposis, or the allergic dermatoses. Maximum dosage should be maintained until symptomatic relief is obtained, then gradually decreased to the minimum dose required to obtain prolonged effect. Self-limited disease states such as serum sickness, drug reactions, and pollen asthma need be treated only so long as the disorder would have lasted without therapy. Severe asthma may require lifetime treatment as with insulin for

diabetes. Other states, where the duration of symptoms may be of unpredictable duration, must be kept under control for estimated periods of weeks or months, therapy then decreased gradually, and resumed for a further period if symptoms recur. Rarely is it necessary to give more than seventy-five milligrams of cortisone daily (fifty of hydrocortisone) for maintenance of effect.

Gradual reduction in dosage when steroid therapy is to be discontinued cannot be stressed too emphatically. It must be remembered that replacement therapy of this type results in suppression of function of the adrenal cortex with more or less disuse atrophy of the gland. Abrupt cessation of treatment, even for symptoms of hyperadrenalism such as sodium and water retention, hyperglycemia and hypertension, may result in grave manifestations of adrenocortical insufficiency. In the need for surgery, even for the correction of such a therapeutic accident as

perforated ulcer, the dose of steroid should even be increased temporarily. Edema occurring during treatment may be controlled by rigid sodium restriction in the diet. Depression of potassium with its resultant weakness is to be countered by administration of a potassium salt, such as the chloride, at the rate of 0.6 gm. with meals. A few "pusher doses" of ACTH to hasten regeneration of cortical activity is advisable on cessation of steroids following prolonged therapy.

Failure to bring symptomatic relief of allergic disorders by means of some combination of the above mentioned remedies will sometimes occur and should stimulate still further search for contributory factors in this group of disorders which result in such a large part of human suffering.

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TAX DEDUCTIONS

AMA Washington Letter, No. 56

The House Ways and Means Committee voted to increase tax allowances for medical expenses by providing that medical costs can be deducted from taxable income if they exceed 3 instead of 5% of adjusted gross income.

Maximum limitations for deductions would be doubled from \$1250 to \$2500, multiplied by the number of exemptions, with a limitation of \$5000 on single taxpayers and \$10,000 for heads of families or married couples filing a joint return. These limits also double those in present law. The tax loss is estimated at about \$119,000,000.

Under the new proposal costs of medicines and drugs could be included in medical expenses only to the extent these items exceed \$50 or 1% of adjusted gross income, whichever is greater. At present it is generally accepted that all medicines and drugs can be included. The government expects by this change to add \$40,000,000 in tax money.

Transportation expenses, where travel is prescribed by a physician, could be deducted but not the cost of meals or lodging. A decedent's medical expenses also could be deducted if paid by his estate.

SYMPOSIUM ON THE COMPULSORY USE OF CHEMICAL TESTS FOR ALCOHOLIC INTOXICATION*

DR. RUSSELL S. FISHER, *Moderator*†

DR. FISHER: Ladies and gentlemen, I am delighted to welcome you to this symposium.

This is the Sixth Symposium sponsored by the Medico-Legal Committee of the Medical and Chirurgical Faculty of Maryland, the Bar Association of Baltimore City and the Maryland State Bar Association.

Tonight's subject is "The Compulsory Use of Chemical Tests for Alcohol Intoxication."

Our panel tonight will consist of Dr. Lewis P. Gundry, Dr. John C. Krantz and Mr. George D. Solter.

They will present their viewpoints on the subject, and then at the conclusion of their discussion there will be a question period, in which first the participants on the panel will exchange questions, and then they will be open to fire from the floor.

You have been provided with pencils and papers, and I suggest that you set down the questions that occur to you as the speakers talk, and then at the end of the presentation, we will gather them and present as many of them as time will allow.

Of course, the Moderator is supposed to introduce the speakers and then shut up, but, in the introduction of the subject of the use of chemical tests, I would like to make three points very briefly. First, I would like to point out that this is a current problem, and that alcoholism is an every-day problem in our courts, to our medical profession and to our legal profession.

To show some figures on the occurrence of this in automobile accidents and homicides, I would like to present very briefly some statistics on the subject.

Table I shows some of the figures in one of the recent years of the degree of alcoholism in victims of homicides in this City.

This is a group of some 68 people who died soon enough after they were assaulted that their alcohol determination would be significant. If you realize that only 21 of the 68 showed no

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† Chief Medical Examiner of the State of Maryland.

TABLE I
Alcoholism in Victims of Homicide

MANNER	TOTAL CASES	ALCOHOL CONCENTRATION—PERCENTAGE			
		None	.01-.09	.10-.40	.40+
Shooting.....	25	5	4	15	1
Stabbing.....	25	7	1	17	0
Blunt force.....	18	9	3	6	0
Total.....	68	21	8	38	1

TABLE II
Alcoholism in Highway Victims, 1950-1951—Baltimore

TYPE OF ACCIDENT	TOTAL CASES	ALCOHOL CONCENTRATION IN BLOOD OR BRAIN		
		Below .04%	0.05% 0.15%	0.15%+
Pedestrians.....	72	44	10	18
Drivers.....	52	20	13	19
Passengers.....	56	41	5	10
Total.....	180	105	28	47

alcohol, and that 39, or 57 per cent showed alcohol in concentrations which indicate that the decedents behavior was probably influenced by it, you realize that a large part of these cases which may be prosecuted as homicides are in fact caused or brought about by alcoholism.

To glance at Table II, which represents the alcohol levels of highway victims in the City of Baltimore over a two-year period, we find more or less the same thing; of the 180 persons who died promptly after the accident, 75, or more than 40 per cent, showed significant amounts of alcohol in their tissues, and the 47 cases who were above .15 per cent constitute 26 per cent of the total. In summary, a study of the people who die of violence of one sort or another, accidental or homicidal, shows that part of the problem, or part of the cause of their death is alcoholism.

Now, this is to be a discussion of the problem in Maryland, and a discussion of the application

of this to your every-day work, and so I would like to call your attention to the wording of Chapter 171 of Article 66½ of the Annotated Code of Maryland. This, of course, is the Motor Vehicle Section, and it refers to driving while under the influence of intoxicating liquor. It says, and I quote, "It shall be unlawful for any person who is an habitual user of narcotic drugs or any person who is under the influence of intoxicating liquor or narcotic drugs to drive or attempt to drive any vehicle, streetcar or trackless trolley within this State."

I think the significant part of that for the discussion tonight is that it states any person "under the influence."

And the definition of "under the influence" operates entirely in the way it is defined.

To get the definition of it, Black's Law Dictionary states this, "The expression is said to to cover not only the well-known and easily recognized conditions and degrees of intoxication but any abnormal mental or physical condition which is the resulting of indulging to any degree in intoxicating liquors and which tends to deprive the driver of that clearness of intellect and control of himself which he would otherwise possess."

Now, this is a rigid definition. It says "to deprive the driver to any degree of that ability to operate a vehicle which he would ordinarily possess."

This is a more rigorous definition than perhaps attains in a place like California, where driving under the influence is interpreted, not in terms of impairment of one's own ability, but rather in terms, let us say, that one shall be adjudged to be under the influence when he impairs his ability to a point below that of an ordinarily cautious and prudent individual. In

that state the ordinarily cautious and prudent man must be anyone licensed to drive. So in interpreting "under the influence" under such a statute, a person is entitled legally to drive, even though he may have imbibed enough to lower his driving ability to the level of the worst driver licensed in the state. That leaves a lot of leeway.

The third question that I would like to raise is just how well are we handling our "driving while under the influence" cases in this State?

There was a recent survey made, and it may interest you a little bit to see some of the figures.

In Baltimore County, where there were 237 arrests last year, there were 144 convictions. That is 60.8 per cent.

In Baltimore City, where a vigorous effort is being made, it showed 64.3 per cent of convictions out of 639 arrests. Not much better. There are other communities, Frederick and Salisbury, where the percentage is 100 per cent, or very nearly so.

The lesson, I think, to be learned from the fact that the Courts convicted 60 to 64 per cent of those arrested and charged is, somewhere between two extremes. On the one hand, we are doing a very poor job of gathering, preserving, presenting and using evidence to indicate that an individual who is charged was, in fact, intoxicated, or we are unjustly charging a large number of people, and embarrassing them and costing them money and great effort to defend themselves against the charge which is unjustly made.

As I say, the truth lies between the two, but the way it is now, it is a very bad situation.

So much for the background of our discussion tonight.

700 Fleet Street
Baltimore 2, Maryland

Our first speaker is Dr. Lewis P. Gundry.

Dr. Gundry received his A.B. at Johns Hopkins University, and his M.D. at the University of Maryland Medical School. He is at present Associate Professor of Medicine at the University of Maryland. He has been Secretary of the State Board of Medical Examiners for six years and since June of this year he has been President of the Board. He has a wide practice,

and he has a wide experience in the field of treating patients to whom alcoholism is a problem. He is going to present to us the physiology of alcoholism, and he will speak of such facts as the absorption of the chemical, the effects on personality of alcohol, and to some extent the ability to relate the effects of alcohol to its chemical content in the blood.

PHYSIOLOGY OF ALCOHOLISM

LEWIS P. GUNDRY, M.D.*

Dr. Fisher, Members of the panel, Ladies and Gentlemen:

I wish to discuss the action of alcohol, and the clinical significance of blood alcohol determinations in alcohol-influence or drunken-driving cases.

Ethyl alcohol has three principal actions. First, it acts as a local irritant; secondly, it is a food, or it has caloric value; thirdly, and most important, it is a depressant of the central nervous system.

It is this third action that we want to discuss principally this evening.

When an individual takes a drink of an alcoholic beverage, approximately 20 per cent of it is absorbed in the stomach, and 80 per cent in the intestines.

The rapidity with which alcohol is absorbed is increased if the person takes it on an empty stomach. Most of us have learned this at cocktail parties or on some other such occasion.

Rapidity of absorption is also increased if the alcohol is taken in concentrated form, such as straight whiskey, as contrasted to beer or wine.

If, on the other hand, an individual has taken a large meal, alcohol would be absorbed more slowly. This is particularly true if he has ingested fat, such as cream. Some people take cream before they go out, because they think they can give a better drinking performance in that way. It is true that alcohol is absorbed more slowly under such conditions; but, nonetheless,

it will catch up with you eventually, as we will try to show.

The concentration of alcohol in the blood reaches its maximum level in an hour and a half to two hours after ingestion, depending on the rapidity with which it is absorbed.

About 95 per cent of this alcohol is broken down or oxidized in the body, and only five per cent is eliminated by the kidneys and by the lungs.

However, there is a constant relationship between the amount of alcohol in the blood, in the urine, and in the expired air.

Alcohol is often erroneously considered a stimulant, particularly by the laity, an idea which is entirely wrong. This mistake is probably made because alcohol in small or moderate doses depresses the higher centers and removes the individual's inhibitions, causing him to be more talkative, more lively and in general more of an extrovert.

However, the real character of alcohol reveals itself as the individual continues to drink; he becomes drowsy, lethargic, and finally passes into a state of unconsciousness, or coma, which may result in death. Therefore it should always be borne in mind that alcohol is a depressant, rather than a stimulant.

I would like to discuss briefly the question of tolerance to alcohol. People who drink regularly and to a considerable extent, will develop an ability to oxidize alcohol more efficiently than the average individual. That is, they develop a tolerance for it. They can take more alcohol

*I am indebted to Dr. Russell Fisher, Dr. Howard M. Bubert, and Mr. G. C. A. Anderson for their advice in preparing this paper.

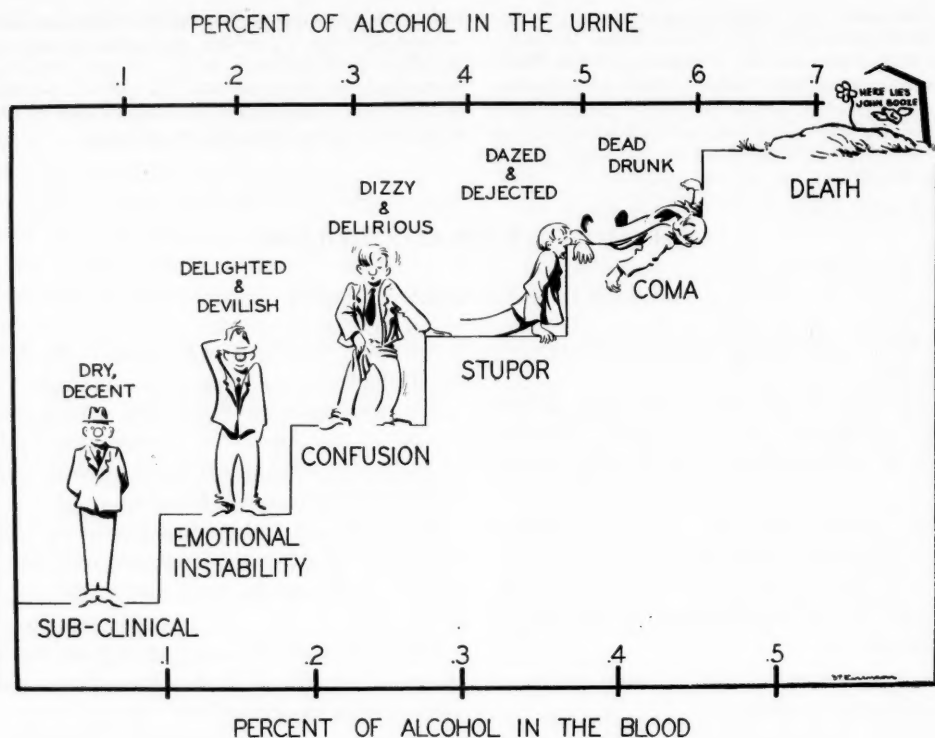


FIG. 1

without becoming intoxicated, and they seem to be able to imbibe better than the occasional drinker.

There are also those with poor tolerance who become maniacal, psychotic and unmanageable after one or two drinks. Fortunately these people are rare. Their condition is known as pathological intoxication.

It must also be borne in mind, in reference to the prolonged, heavy drinker, that after a number of years he will begin to lose his tolerance; after a certain period his tolerance declines and he may become intoxicated on only one or two drinks. This fact, I think, is important in relation to the subject we are discussing tonight.

Thus you see that capacity or tolerance will vary greatly in different individuals, or in the same individual under different conditions and at different times. The blood alcohol level,

however, can be correlated more accurately with the degree of intoxication or alcohol-influence.

Muehlberger¹ states that while there is a wide range of tolerance to alcohol which is swallowed, there is very little difference in the reaction of various individuals to a given level of alcohol circulating in the blood. In other words, all men with the same blood alcohol level are approximately equally intoxicated, within an error of plus or minus ten to fifteen per cent.

The blood alcohol level in terms of clinical intoxication is illustrated in Figure 1. As depicted, the individual with a blood alcohol level between zero and .1 per cent is described as "dry and decent," or subclinically intoxicated. However, as demonstrated in experimental work these people are not free from errors in driving automobiles, so that they are not quite as

innocuous and debonair as they might appear to the public.

The next level is .1% to .2%. In the middle of this group comes the zone of clinical intoxication. As given by most authorities on pharmacology it is .15%. The man is called delighted, and devilish. There are signs of emotional instability, decreased inhibitions, and slight muscular incoordination.

The next level which represents definite intoxication is .2% to .3%. He is "dizzy and delirious." He becomes confused, and reveals disturbances of sensation, decreased pain sense, staggering gait, and slurred speech.

At the level of .3% to .4%, he is very drunk. He is dejected, and has a marked decrease in response to stimuli, as well as muscular incoordination, with approaching paralysis, and complete unconsciousness.

Finally, between .4% to .5% (which has been given as a fatal level), he is in coma, with complete unconsciousness, subnormal temperature, and anesthesia.

And the last stage (.5% and above) is that level at which people frequently die. Figure 1 gives you an idea of the significance of various blood alcohol levels with corresponding percentages of alcohol in the urine.

It is important to remember that .15% is the level at which a person is definitely considered by most pharmacologists to be under the influence of alcohol, or intoxicated.

In the light of this data, let us consider the effects of various concentrations of blood alcohol on driving ability.

In a carefully controlled series of experiments Bjerver and Goldberg² tested 37 expert drivers. These men taught driving for a livelihood. They were at least theoretically, the best drivers obtainable for this experiment. These drivers were subjected to a series of driving tests. I won't go into detail, but very sketchily, there were five or six tests. The tests consisted of backing a car in and out of a garage; parking it; backing it onto a plank (getting two wheels on

the plank); going around a curve and knocking over obstacles on the left, and driving out of a sand pit.

The 37 drivers were divided into two groups: The first group we will call the control group; these drivers had no alcohol. They were tested, however, for alcohol, just to make sure that they had not slipped around the corner and obtained a drink beforehand. However, no alcohol was found in their blood. They did the above series of tests; waited two hours, and repeated the same tests. In the control group, there was an improvement of 20 per cent in driving ability on the second performance of the tests.

The second, or drinking group, was again divided into two classes: One class was given three or four bottles of beer over a period of ten or fifteen minutes, and the other class was given three or four ounces of whiskey, over a period of five or ten minutes (after they had done the tests the first time). About an hour or an hour and a half after they had been given the alcohol, they repeated the tests. The average blood alcohol level of those who had been drinking beer was .04%. That is less than a third of the level (.15%) for clinical intoxication. The average blood alcohol in those who had been drinking whiskey was slightly higher; it was .06%. In the two groups, it averaged .05%.

In those who had been drinking beer, there was a deterioration in driving. Instead of improving 20 per cent (as noted with the control group) they fell off 18.6 per cent. In those who were drinking whiskey, there was a decrease in driving ability and skill of 32.7 per cent.

Thus drivers who had ingested a relatively small amount of alcohol showed a very definite decrease in driving ability. This was found in all individuals; it varied slightly, but they all showed impairment of driving ability and judgment. As an example, one driver who tried the backing-up test attempted it thirty times without succeeding. He was still trying the same way at the end of the thirtieth time; this will give you an idea of what sort of driving he was doing.

This series of tests seems to me to offer conclusive proof that even a low level of alcohol in the blood definitely impairs driving ability. According to Sollmann's³ Text Book of Pharmacology, .15 per cent of alcohol in the blood is generally accepted—and I quote—“as the critical concentration for the chemical diagnosis of drunkenness,” or alcohol influence, if you prefer that term. Incidentally, to attain a level of .15 per cent, a person has to drink six or eight bottles of beer, or six or eight ounces of whiskey; twice the amount which was used in the above test.

The National Safety Council has reported that drivers with .15 per cent or more of alcohol in the blood have an accident rate of fifty-five times that of non-drinkers.

The National Safety Council and the American Medical Association have made recommendations for legislation which utilizes blood alcohol determinations. These recommendations are embodied in the statutes of Indiana, New York, Maine and Oregon (very similar in all these states), with the following three conditions:

1. With less than .05 per cent alcohol in the blood or equivalent amounts in other body fluids, the subject will be considered not under the influence of alcohol.

2. When there is .15 per cent or more alcohol in the blood or equivalent amounts in other body fluids, the subject is presumed to be under the influence of alcohol as far as the operation of a motor vehicle is concerned.

3. When there is between .05 and .15 per cent alcohol in the blood or equivalent amounts in other body fluids, there is a question of alcohol influence. In other words, the blood alcohol is considered along with clinical observations or other tests.

A very similar Bill (which was reported unfavorably) was brought up in the 1953 Maryland Legislature (H. B. 297). This Bill had exactly

the same three criteria for alcohol influence as the statutes of the four states of New York, Maine, Oregon and Indiana.

In other words, blood alcohol levels below 0.5% are not considered under the influence; above .15%, you are under the influence and not fit to drive a motor vehicle; and between .05% and .15%, it is questionable.

There was another paragraph in the Maryland Bill which I consider important. Paragraph 4 of this Bill reads, “The foregoing provisions shall not be construed as limiting the introduction of any other competent evidence bearing upon the question of whether or not the defendant was under the influence of intoxicating liquor.” Thus allowance was made for a clinical examination, and for any further evidence that a person might desire to produce in an individual case.

After careful thought about this matter, it is my considered opinion that we should have in Maryland some legislation which uses chemical tests to determine the degree of alcohol influence in drivers charged with motor vehicle violations. Let me hasten to add that I do not believe that the courts should decide any given case on the basis of chemical tests alone. They should utilize all other competent evidence bearing upon the question of whether or not the defendant was under the influence of intoxicating liquor.

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DR. FISHER: Thank you, Dr. Gundry.

DR. FISHER: Our second speaker of the evening is Dr. John C. Krantz, Jr.

Dr. Krantz is well known to most of you as Professor of Pharmacology at the University of Maryland Medical School. He has lived in Baltimore a long time and is well known in his field.

He trained first in pharmacy, and subsequently in pharmacology, at the University of Maryland. He has conducted research on anesthesia and on the problem with which we are concerned, the effects of alcohol.

He is well known as the co-author of a leading text book on pharmacology, entitled "Pharmacologic Principles of Medical Practice."

You perhaps know he is also the co-author of a book on public speaking.

Dr. Krantz will discuss the principles of analysis for alcohol in the blood, the urine and the breath, and he will have some further remarks on the interpretation of blood levels as they are met with in clinical practice.

Dr. Krantz.

THE PRINCIPLES OF ANALYSIS FOR ALCOHOL IN THE BLOOD, THE URINE, AND THE BREATH

JOHN C. KRANTZ, JR., PH.D.

Mr. Chairman, members of the Panel, members of the Bar Association, and members of the Medical and Chirurgical Faculty:

I do not believe there is any subject upon which there is more misinformation extant than that of alcohol.

It appears that an ardent prohibitionist, a well-meaning lady, was giving a demonstration one day to a group of children in school. She had a glass of water and a glass of alcohol. Into the glass of water she put several garden worms, and the worms remained viable. And then into the glass of alcohol she placed several garden worms. They immediately died. Then she looked around the class, and there was little Billy sitting down there, and she asked for an interpretation of that experiment. And Billy quickly answered and said, "Well, ma'am, that would indicate that if you have worms in the gastro-intestinal tract, you better take whiskey."

It has been pointed out that when alcohol is taken by mouth and ingested, it is rapidly absorbed from the gastro-intestinal tract. And this poses the very important question: Is alcohol normally in the blood of a person who has never imbibed alcohol? The answer to that question is yes. The food which we use for the body and which is our greatest source of energy is glucose— $C_6H_{12}O_6$ —and when glucose is broken down in the body into carbon dioxide and water, alcohol, C_2H_5OH , is also formed. If one examines the brain of anyone in this room at the present time,

the concentration of ethyl alcohol will be found to be 0.0004 per cent. That of the blood is 0.004 per cent.

What is more, in the pig, in the dog, in the bird, and in the chicken, one finds alcohol normally in the blood, owing to the fact that in the oxidation or the burning of sugar in the body, alcohol is an intermediate product.

Does this amount of alcohol produce symptoms of intoxication? Obviously not, or we would all be drunk at all times.

When alcohol is ingested by an individual it passes out of the gastro-intestinal tract into the general circulation. It is so uniformly and evenly distributed, that one might think of an individual as a sponge which has been dipped in alcohol, and absorbed the alcohol uniformly throughout. For example, if one sets the amount of alcohol in the brain at one, the amount in the blood will be 1.17, and the amount in the skeletal muscle will be 0.90, and the amount in the liver will be 0.91.

This is important, because of the fact that if one takes a sample of blood from an ear, or a sample of the urine, one can get a very good estimation of the amount of alcohol which is circulating through the brain, which is, in turn, the organ on which alcohol has its profound effect.

It has been pointed out by Dr. Gundry that when alcohol undergoes oxidation in the body, carbon dioxide and water are formed.

Let us ask ourselves this question: How about

the curve of alcohol disappearance from the blood? This is important from a medico-legal standpoint. Let us plot as ordinates on a curve concentrations of alcohol in the blood, as 0.05, 0.1 and 0.15 per cent. Also let us plot the times in minutes. Let us say 30, 60, and 90 minutes. Immediately, five minutes after the alcohol has been ingested, it is rapidly absorbed, and the curve of ascendancy in the blood goes up very rapidly. As it is oxidized, the curve of disappearance comes down slowly. The period of greatest intensity of symptoms in the individual is when this curve is on its ascendancy. For example, at one point, let us say that at .075 per cent, on the ascendancy curve, an individual will be far more under the influence of alcohol than if you consider him thirty minutes later, on the descendancy curve, even though the alcohol blood levels are the same.

The reason for that is perfectly apparent. As the cells of the central nervous system are being acclimatized to the presence of alcohol, it has the greatest effect. After the acclimatization has taken place there is a gradual wearing-off of the effect of the alcohol as it is metabolized.

Dr. Gundry has pointed out that alcohol is a food. If alcohol is a food, there are a few pertinent questions to ask about it. Is it a good food? Yes, it is a good food. Each gram of alcohol supplies seven calories of energy; a gram of carbohydrate, four; a gram of fat, nine; a gram of protein, four. Therefore alcohol is intermediate between carbohydrate and fat as a source of energy.

Is it a good source of food? No, it has to be burned immediately. We cannot store it in our liver and muscles as we can carbohydrate.

It is very interesting to note that when alcohol is burned in the body, the rate of burning of most individuals remains the same. If one takes the ideal man, of seventy kilograms, or 150 pounds, he can burn in the course of an hour about 12 cc. of alcohol.

How much whiskey is that? That is 24 cc. of whiskey—two thirds of an ounce of whiskey.

If he gets his alcohol at that rate, he very

seldom will ever exceed 0.04 per cent in his blood, and his symptomatology will be very low. The alcohol will serve mainly as a food and not as a drug.

The amounts of alcohol in the quantities that are found in the blood after the ingestion of large quantities of alcohol in the form of beverages can be estimated very accurately by chemical methods.

We know that in the human body alcohol is oxidized, and the products of metabolism are CO_2 and H_2O , identical with the products of metabolism of sugar.

Now, then, one may oxidize alcohol with chemical reagents. When one does this, by measuring the amount of reagent used by the alcohol, it is possible to tell how much alcohol is present in the blood, or in the organs, just as one can determine how much sugar is present in the blood.

Let us illustrate. There is an instrument known as the "drunkometer." The drunkometer depends upon the use of a chemical known as potassium permanganate. As most everyone knows, this is a chemical that is purple in color. This substance is an oxidizing agent. It will supply oxygen to the alcohol, converting it to carbon dioxide in water, and it will become colorless.

Now, for example, one may volatilize the alcohol out of the blood. By allowing the volatilized material, which is the alcohol, to come in contact with the potassium permanganate, a portion of the permanganate is decolorized. But one has found through very careful examination of many people who drink alcohol that some of it is eliminated in the exhaled air. The amount depends on the amount of alcohol in the blood. That relationship is this: The amount of alcohol in the blood is two thousand times that amount of alcohol in the exhaled air.

Let us think about that a moment. Why should it be so little in the exhaled air? Well, 95 per cent of alcohol is metabolized, and about 3 per cent is excreted in the urine, and about 2 per cent is excreted in the exhaled air. Therefore,

the relationship, which incidentally is a rather constant one, between the amount of alcohol in the exhaled air and the amount of alcohol in the blood is a reliable one.

Another device which is used for the determination of alcohol in the exhaled air is the "Alcometer."

The principle is essentially the same. A material known as iodine pentoxide supplies oxygen to the alcohol and converts it to carbon dioxide and water. The iodine reacts with a starch paste and sets up a blue color, the intensity of the blue color is picked by a photo-electric cell. From these data one can definitely determine the amount of alcohol in the exhaled air. This when multiplied again by our factor of two thousand gives the amount in the blood.

One might ask the question, are these tests infallible? No. No chemical test is infallible. And the question can be asked, does one have to be very careful about conducting them? Yes, one has to be extremely careful, extraordinarily careful, but yet in the hands of a skilled technician, the test works out very well.

When the drunkometer was first developed, they used it to find out the condition of the operators of motor vehicles in and about the City of Chicago. They got a laboratory test truck to go out on the roads with men dressed in white. Drivers were stopped and addressed in a very polite way, "Would you let me have a sample of your exhaled air?" Few objected. They were rather proud to blow a sample of their breath into the container with the colored solution of potassium permanganate. When no decolorization occurs one was told to get back into the car, "You have no alcohol present in your blood."

One of the first steps was directed toward determining when the drinking would take place. They found that of those driving at noontime only about two per cent had been drinking. But between twelve Saturday night and two A.M. on Sunday, one finds that this goes up about twenty-five per cent. So then you ask the question, well who are these people? The

age peak falls between twenty-five and thirty, with equal distribution between the sexes. In other words, there are as many women as men drinking between the ages of twenty-five and thirty years and operating a motor vehicle while under the influence of alcohol.

Dr. Gundry and I discussed the tests that were carried out in the Caroline Institute in Stockholm, Sweden, which he so excellently delineated for you.

I would like to make one or two other comments with regard to these tests.

Those individuals, who were expert drivers, were shown to have an impairment of their driving ability under the influence of alcohol, and under the influence to the extent of about 0.04 per cent. These same individuals were subjected to the so-called flicker fusion test, which determines the acuity of one's vision to watch a flicker of light fuse into one light as the intensity of the light is increased. These people under the influence of alcohol deteriorated thirty-seven per cent in the flicker fusion test.

Again, they tried these people with the so-called "blink test." In this test there is a jet of air which is directed against the cornea. The degree of pressure which is required for the individual to cause blinking is determined.

These drivers again deteriorated to the extent of thirty-three per cent in their performance after they had alcohol in their blood to the extent of 0.04 to 0.056 per cent.

It seems to me that the evidence is quite clear that: One, we know where the alcohol goes in the body; two, we know by chemical means that the amount of alcohol that can be determined with a fair degree of reliability; and three, we are nearly certain that the symptomatology, the measurement of one's acuity of vision, of hearing, and so forth, parallels the alcohol concentration in the blood of those individuals who ingest it.

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DR. FISHER: Thank you, Dr. Krantz.

DR. FISHER: I believe that the medical men have now established for us the background, insofar as the scientific part of the alcohol test is concerned. And we now are going to turn to the other portion of this, which is the application of the test to the problems that face us in court every day.

To cover this phase of the subject, Mr. George D. Solter has been asked to address you.

Mr. Solter received his schooling here in Baltimore. He received his A.B. at Johns Hopkins University, and his LL.B. at the University of Maryland.

He was for a while engaged in the private practice of law

in Baltimore, and more recently, for some three years, has been associated with the State's Attorney's Office in this City.

Mr. Solter was the first State's Attorney to be assigned to the Traffic Courts last year, when it became evident that the real assistance of the State's attorneys was needed in the handling of drunken driving cases. He served for quite some months there, and I assure you he can talk from his experience.

I believe he is going to restrict himself to the legal questions, and the questions whether this is proper evidence, and what is apt to happen with such evidence here in Maryland.

Mr. Solter.

APPLICATION OF THE TEST TO THE LEGAL PROBLEMS

GEORGE D. SOLTER, ESQ.

Dr. Fisher and fellow members of the Panel, members of the Committee, and ladies and gentlemen:

As Dr. Fisher has just told you, I have been asked to give the lawyer's approach to this problem, and although I am at present and have been in the Prosecutor's Office, I will attempt to make my remarks applicable to both sides of the problem, that is, from the defense lawyer's standpoint and the standpoint of the Prosecutor.

Of course, everything I say is based upon the assumption that everything these gentlemen have said is scientifically and medically correct. If what they have said is not, then anything I say on the subject is of little help, because we have to rely upon the accuracy of their studies, and the studies of those who work with them in other states in the same field.

In recent years, the public has become increasingly aware of the menace of the driver of an automobile who is under the influence of liquor, or, as he is commonly known, the drunken driver. Fourteen states have already placed upon their statute books new laws which finally put teeth into the law making it a crime to operate an automobile while under the influence of alcohol. These new laws have led to the introduction in the courts of the various chemical tests for alcoholic intoxication, which have just been described to you. In some states, the tests are compulsory. In others, the results of the

tests are made admissible in evidence, if voluntarily given by the suspect. And in still others, the term "under the influence" is merely defined in terms of the tests in the event that a test was made and offered and accepted in evidence at a trial.

In 1952, the peak of public attention to the problem was reached here in Baltimore after a tragic fatal accident and the trial of the driver involved, who was charged with "operating under the influence." As a result of this, an Assistant State's Attorney was assigned to the Traffic Court by agreement of the State's Attorney of Baltimore and the Chief Magistrate of the Traffic Court, to prosecute all "under the influence" cases.

Now, I might say right there that the reason for that coming about is that a Traffic Court is a less formal court than the courts of the Supreme Bench of Baltimore City, and the Circuit Courts of the Counties, and there is a tremendous volume of traffic offenses handled there every day.

Under the normal situation, the police officer appears as the prosecuting witness and presents his own case. The Magistrate hears the evidence, and the defendant tells his story. Of course, if there are other witnesses for either side, they are brought in to testify.

It became apparent that these operating "under the influence cases" were serious matter. In almost every case the defendant was repre-

sented by counsel, and the Magistrate was placed in a dual capacity of being the prosecutor as well as the sitting judge. This placed a very heavy burden on the police officer, who had to present his own case.

In recognition of these factors, the triangle was completed by placing the prosecutor there to present the State's evidence, and to relieve the Magistrate of the dual function of having to try to direct the testimony out of the State's witnesses, and then in fact sit in judgment on the case.

Although this change helped the situation immeasurably, it was obvious that the law was not definitive on the question and must be changed in order to give the courts a scientific standard to help measure the term "under the influence," in addition to the other competent evidence to be presented.

In recognition of this need, House Bill 297 was introduced in the Maryland Legislature last year, but, unfortunately, and contrary to what my brother here said about the progress of the Bill, my information is that it died in committee, and never got out at all.

This Bill was, in the words of those who opposed the use of tests generally, the least obnoxious, in that it merely established certain presumptions, should a chemical analysis of the defendant's blood, urine, breath or other bodily substance be introduced in evidence. The three presumptions were as follows:

1. If the percentage was .05 or less, he is presumed not to be under the influence of intoxicating liquor.
2. If the percentage was in excess of .05 but less than .15, no presumption arises, but the presence of alcohol in the blood may be considered in determining guilt or innocence.
3. If the percentage was in excess of .15, he is presumed to be "under the influence," but that, of course, is a rebuttable presumption.

The law made it clear that the test was not to be the sole measure, and its use was not to limit the introduction of other competent

evidence bearing on the question of whether or not the defendant was under the influence.

Since this Bill never became law, today we are still faced with the same problem in court, and many dangerous drivers are acquitted, to return to their automobiles, perhaps to kill or maim; and occasionally an innocent person may be convicted. Perhaps at the next session of the Legislature, the Bill or a similar one, may pass, but until it does, the courts must continue to face the vague, biased, inaccurate and inconclusive evidence often placed before them by the witnesses.

To illustrate what I mean here are some typical bits of testimony that you will obtain in these cases.

You may have testimony to the effect, that at the scene of the accident one of the motorists is very irate and aggressive, and he protests to everyone, and when the police arrive he says, "Arrest that man, he is drunk."

The officer then goes about his investigation, and he may or may not feel the same way that the motorist does, but anyway, on the basis of that complaint, he places a charge of "operating under the influence" against this individual.

Well, a lot of things can happen between the time of the accident and the time that this case comes up in court.

One thing that can happen is that the irate motorist gets a nice check from the insurance company, or from the other party, for his damages, so that when he gets into court, the pressure is off, and he is satisfied, and under examination he will say, "Well, I am not sure, I did smell alcohol, but I could not be positive that he actually was under the influence." And so your testimony begins to fall apart.

Then you have the case where the motorist comes through with flying colors, backs up his statement that he has made at the scene, and so testifies in court. However, the officer may come in and say, "Well, I could not say that this man was actually under the influence from what I observed about him."

Thus you have a conflict in the State's evidence right there, raising a rather serious question of doubt in the mind of the Magistrate, and there is nothing else for him to do but to throw the case out.

Then you have the injury alibi situation, where you establish your case all right, where everybody says the operator appeared to be well "under the influence" from all external things, such as slurred speech, staggering, bleary-eyed, and the odor, but the defendant then takes the stand and he says, "Well, there was an impact, my head bumped against the steering wheel, and I don't know, I don't remember too much about what happened." Of course, there is no physical evidence on the man that he was injured, but there you are. You don't know what to do with a thing like that.

These are just some of the things that we run up against in trying these cases strictly on the physical evidence that can be gathered from the people at the scene.

To point up the essential need for and the value of chemical tests of alcoholic intoxication, let me summarize a recent case in a state which had compulsory tests. There was an accident between two automobiles; one a sport model driven by a youngster, the other an expensive sedan operated by an elderly, well-dressed man. The youth staggered from his car, and the odor of alcohol was obvious from several feet away. His speech was slurred, and at times unintelligible. From the crowd which had gathered came words such as, "He sure is plastered—hope he gets what is coming to him."

Then the other driver calmly surveyed the situation and with steady gait, approached the police who had arrived at the scene. The youth was unable to give his address, state where he was or the day of the week, but he steadfastly denied that he had had anything to drink. He was given the balloon test, one of these breathing tests which have just been discussed. The older man, who admitted a drink or two

several hours earlier, but who had no odor of alcohol on his breath, was given the balloon test also, "Just for the record."

Well, as a result of these tests, the older gentleman was later tried and convicted of operating "under the influence," and the boy was sent immediately to the hospital for observation and was found to have a concussion. Much to the amazement of all witnesses, and the police, the tests showed no alcohol present in the boy's blood and .25 per cent in the older man's blood. The strong odor of alcohol on the youth was found to have come from a broken radiator and anti-freeze which had sprayed on his clothes at the time of the accident.

Can anyone doubt that the result of this case would have been the reverse if these tests had not been available and used? Perhaps a life as well as a reputation may have been saved.

Perhaps the most tenuous problem, from the lawyer's standpoint, will arise out of the question of the admissibility of the results of a chemical test where the test has been made compulsory by law. This problem can be broken down into two questions:

1. Does the taking of a sample of blood, breath, urine or other body substance for the test violate the constitutional right of the individual to refuse to testify against himself?
2. What expert testimony should be required to introduce the results of the test as competent evidence?

Dealing first with the question of constitutionality, we should examine the Maryland law and the cases that touch upon the point. There are two recent Maryland cases which may help us draw certain conclusions, but I do not feel that either settles the law, or would be controlling if applied to compulsory chemical tests for alcoholic intoxication. In *Shanks vs. State*, in 185 Maryland Reports, at page 437, decided in 1945, the Court of Appeals held that a test of blood found on the coat of the accused, who was charged with rape, was admissible against him, when this test was used for comparison with other tests of blood from the victim of the

assault, blood from an alibi witness, and blood found at the scene of the crime. The Court distinguished this case from another in which it was held to be error to force an accused at his trial to try on a hat, which had been found at the scene of the crime. In that case, while the defendant was in court, in the progress of the trial before the jury, the State attempted, over the objection of the defendant, to place a hat that had been found at the scene of the crime on his head, to see whether it fit or not, and the Court allowed it, but the Court of Appeals reversed the Lower Court and said that this was forcing a man to incriminate himself. The Court had this to say:

"The difference is, . . . that when such comparisons and experiments are made outside of court, the evidence falls from the lips of witnesses other than the defendant. The production of such evidence, therefore, and the testimony thereto, is not that of the defendant but of other witnesses, while on the other hand, if the defendant is required against his objection in open court, in the presence of the jury, to make such experiments and comparisons, no extraneous evidence is required and the constitutional prohibition is thereby violated."

It must be noted, however, that this case dealt with blood from the coat of the accused and not with a sample of his own blood taken from him. It, therefore, seems to be open to question as any precedent in the problem we are discussing.

The other case, which seems to me is a strong authority for the constitutionality of the compulsory tests, is *Davis vs. State*, 189 Maryland Reports, at page 640, decided in 1948. In this case a murder suspect had taken a quantity of iodine in an apparent attempt to take his own life. After treatment, he was placed in a cell in the County jail and treated by the County Medical Officer. The following day he was visited by another doctor, who took a specimen of the defendant's blood. The doctor said nothing of his reasons for taking the blood,

except that it was at the request of the State's Attorney.

At the trial of the suspect, the results of a test made on this specimen of blood were introduced over objection of the defense, along with the results of tests of blood from the murder weapon, from clothing of the deceased, and from clothing of the accused, to show a comparison of the blood groups found. On appeal, the defense contended the blood from the defendant was taken from him by a subterfuge, and, therefore, violated his constitutional immunity to testify against himself. The alleged subterfuge was based on the defendant's belief that the specimen was being taken for use in connection with his own treatment for iodine poisoning, and, therefore, was not given with his consent for the purpose for which it was used at his trial.

In this case, the Court held, after stating that the question should be viewed as if the evidence had not been obtained by the completely voluntary action of the accused, that the case was one which fell into the class of cases where physical evidence had been obtained before trial and had been offered against him at the trial. In affirming the action of the trial court, the Court of Appeals said:

"We are unable to see where there is any constitutional question involved in this case. There is no substantial difference between obtaining a specimen of blood from an accused and obtaining his finger prints, or any other physical property, the possession of which by him is a pertinent question at issue in a felony charge against him. . . ."

Now, for you lawyers who are present, it is perfectly true that this case involved the commission of a felony, whereas "operating under the influence" is made a misdemeanor. It would seem to follow, however, that if the blood test was admissible in a homicide case, which is a felony by common law, and involves the possible death penalty, it would be admissible in misdemeanor cases, where far less threat to life and property of the accused is present, even

though the Maryland law does draw some distinctions between the admissibility of evidence in felony and misdemeanor cases.

That is a rather broad principle, which we do not need to go into here tonight, and which I am not going to go into. But for the purpose of this discussion I feel it would make no difference, and I feel definitely that the Courts would rule that since "operating under the influence" is a misdemeanor, and a lower grade of crime, that they would follow the other case, where they allowed this to come in as a felony.

The argument of those who oppose the use of compulsory chemical tests, on the basis of unconstitutionality, centers on the theory that although the evidence or specimen has all the characteristics of physical evidence, it is still in the nature of something coming from within the accused himself and is, therefore, comparable to words of an incriminating nature either spoken or written by him.

Thus it seems to me that although the question is still not completely answered, the Davis case, which I have just discussed, appears to be a strong authority for the constitutionality of compulsory tests in Maryland. If you are interested in any further discussion on that point in other jurisdictions, where the authorities are divided, reference is made to 164 American Law Reports, from page 952 through page 967.

Now, as to the question of expert testimony, some aspects of which have been dealt with by Dr. Krantz, the usual rules of evidence as to experts would prevail. The party offering the expert must show the qualifications of the expert as to training in the field, experience and general knowledge of the subject matter. His opinion concerning the results of the tests is admissible once he is qualified and once the proper foundation has been laid for the introduction of the results of the test. By the latter, I mean that the party offering the results of the test must show the conditions under which the test was made, prove that the chemicals

were compounded to the proper percentage for use in the testing instrument, and prove the custody of the specimens from the time of taking to the time of calculation or analysis of the chemicals, showing thereby that the specimen was, in fact, taken from the accused and that it was not altered or otherwise changed between the sampling and the calculation.

Now, that is the burden that rests upon the State to even offer the tests at all before it gets the expert to tell what the tests mean.

As a practical matter, it is my opinion that once the practice of using the tests becomes general, the expert testimony itself will be replaced by a written report of the expert, providing the foundation for the introduction of the test results can be satisfactorily laid. Such is the case today in most homicide trials where counsel usually agree to submit the autopsy finding, without requiring the doctor to be present and testify as to the fact and accuracy of the autopsy itself.

Of course, we have lots of cases where we call Dr. Fisher and his colleagues in, where the question is in dispute, of whether or not the wound could be caused by the alleged murder weapon and where the actual cause of death is in dispute. The defense counsel usually want him present, to see if they can break him down. They are not very successful.

There are many other facets to the whole question, which are too numerous to discuss at length. Most of these will resolve themselves after a determination of the constitutionality issue. I am referring to the need of advising the accused that the information derived from the tests may be used against him in court, the admissibility of the fact that an accused refused to submit to the test, and finally the validity of a penalty imposed by law on an accused who refused to submit to the test. There are some states that have that provision.

Obviously, if compulsory tests are held to be constitutional, then these other questions become moot, but if the compulsory feature of

the law is not sanctioned, then it would seem that the introduction of the results of a test might be subject to some of the same requirements of evidence which now surround the introduction of an incriminating statement of an accused in any criminal proceeding.

Thus, after a review of the factors giving rise to a need for compulsory chemical tests of alcoholic intoxication, and of the law of Maryland and other jurisdictions on the question of admissibility of the results of such tests, it would seem to me, from the lawyer's standpoint, that a law based on the scientific approach, as given by Dr. Krantz, is highly desirable and would accomplish the following objectives which are important to all of us.

1. The elimination of guesswork from the prosecution of driving "under the influence" cases.

2. The removal of the drunken driver from our streets and highways.

3. The protection of the occasional drinker, who may be competent to drive, but victimized by the circumstances surrounding an accident in which he may be involved.

4. The giving of prompt medical attention to persons who may be injured and at the time

show the physical manifestations of alcoholic intoxication.

I think we are all seriously and sincerely dedicated to these objectives, not only those in the law enforcement field, but all concerned. Even defense counsel, who appear in Traffic Court frequently representing clients charged with this offense, should welcome it, because in many cases it will let their man out right off the bat, without any trouble at all, if he does not have enough on board to meet the requirement.

I want to thank the Committee for asking me and giving me this opportunity to make a few remarks on this subject, because I feel it is a vital one, and I think that public interest in it may help us the next time we get a crack at the Legislature to do something about it. I thank you very much.

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DR. FISHER: Thank you, Mr. Solter.

May we take just a minute now and ask a couple of the folks in the front row if they will go back and pick up any questions that may have been written. And may I ask you to pick them up and present them to Mr. Stanley, over on the side, who will organize them for presentation while we are asking other members of the panel some questions that have already been presented for our study tonight.

QUESTION PERIOD

DR. FISHER: Among the questions that are immediately proposed is the following one, which is directed to Dr. Krantz.

Q. What illnesses, injuries or other conditions of an individual can produce the outward appearance and symptoms of intoxication without any significant amount of alcohol being present in the system?

DR. KRANTZ: Insulin shock may produce a syndrome comparable to alcoholic inebriety.

What is more important, one finds that febrile conditions can produce disorientation of an individual. Certain types of pneumonia may do this. The administration of many drugs will

produce a syndrome comparable to the condition of inebriety. For example, the antihistamines can produce drowsiness, and inability to think quickly and alertly, with diminution of acuity of vision, and hearing. We find that such old-fashioned drugs as paraldehyde or chloral hydrate may produce a syndrome comparable to alcoholic inebriety. And we find that such drugs as atropine, when given in toxic doses, will produce hallucinations, disorientation and amnesia, which is again a syndrome comparable to alcoholic inebriety.

DR. FISHER: Thank you, Dr. Krantz.

It appears that a good many medical condi-

tions may confuse a physician, and it may be that too many questions may produce the same effect. But I hope not.

Q. Here is a question directed to Dr. Gundry: Does an old toper absorb alcohol as fast as an uninitiated individual?

DR. GUNDRY: I think I may have partially answered that in my brief talk, but, as a general rule, when he is at the peak of his prowess as a drinker, he probably absorbs alcohol faster than the average or uninitiated drinker. However, after he passes the peak and begins to deteriorate, he does not absorb it as well. As I mentioned, he may develop high levels of blood alcohol with a relatively small amount of alcohol ingested.

Q. Could we follow that up a little bit more? This old toper who absorbs alcohol rapidly, just where does he stand in respect to the fellow who drinks a quart a day, and yet who never appears drunk? How can he keep up with that situation, when you or I go out and have seven highballs and are not eligible to drive an automobile? What is the difference? Is there a difference of ability to tolerate the alcohol, or is it an ability to burn up the alcohol, so that we do not get a high level? This is an important question, Dr. Gundry.

DR. GUNDRY: That is a pretty hard question to answer. However, I will stick to what I said, that I believe that two or three individuals, regardless of their experience and their ability to drink, if you find them with the same blood alcohol, they will be about equally incompetent to operate a motor vehicle.

DR. FISHER: I think that is an important question that repeatedly occurs to those of us concerned with the problem.

Mr. Solter, I have one for you.

Q. How does the law which utilizes blood alcohol tests work out in the fourteen states where they now have such a law? Can we learn now about some of the points in Maryland, in comparison with the other states?

MR. SOLTER: I am not going to answer that

question on the basis of constitutionality, but rather on the basis of practicality.

From the literature that I have read on the subject, where these tests have been used in many other states, the most significant thing reached is that the conviction rate is up around 90 per cent or better.

Now, there are a lot of reasons for that.

I think one significant reason is that by the use of the test at the scene, and a rapid calculation made, many people are never even charged, because the result of the test would indicate to the authorities that the person was not sufficiently under the influence to warrant even the issuing of a ticket. So that you eliminate that group right at the source.

And then jumping to the other extreme, where you get a test that shows a high percentage, you get a high level of guilty pleas. And so that helps a great deal. You save a lot of time, and it makes it easy for the Magistrate. I think the statistics do show that a far more effective enforcement situation exists where they do have the tests.

DR. FISHER: Thank you.

Here is a question which seems to be directed to me.

Q. Of what particular value is such a test when there are different degrees of alertness by the driving public? In other words, one person who may be alert and intelligent, even when under the influence of alcohol, would still be more alert than some dull-minded person who has never touched a drop of alcohol.

This, to be answered, involves saying simply that under the law of our State, "under the influence" is defined in terms of significant impairment of one's own ability to operate a motor vehicle. In other words, it is the presumption that each citizen has certain duties to the general public to maintain himself in his best driving capacity. And even though there may be a few dull drivers, who are very poor drivers, and who may even go around killing people, that does not allow the rest of us who

are good drivers to get ourselves so tanked up that we become as big a danger as those very poor drivers.

Here is another question, one which I think one of the panel might answer. It gets down to the question of percentage.

Q. What does the alcohol present in the blood of an individual represent in relation to the amount of alcohol actually consumed by the individual?

This has been touched upon, but I think it might be repeated, because it is the current belief that one can take a drink and still be a safe driver.

DR. KRANTZ: Dr. Gundry has touched on this problem this evening, but I want to give you certain percentages of alcohol that have resulted in the blood of individuals who have ingested definite quantities of alcohol.

Miles, in England, some ten or fifteen years ago, took a number of individuals and gave them 34 c.c. of absolute alcohol. That would be 100 proof. And we find that this alcohol was diluted to 100 c.c. and that in turn would be comparable to a 34 per cent alcoholic beverage. A weak whiskey, in other words. And the individuals who took this had an average concentration of alcohol in their blood of 40 milligrams per cent, and on the other hand, when this same amount of alcohol was diluted to a thousand c.c. it was 34 milligrams per cent instead of 44 milligrams per cent—the concentration in the blood was far less.

There is another point that I would like to emphasize with regard to drinking, and the amount of alcohol in the blood.

This experiment has been repeated many times.

If you take a non-initiated individual with this amount of alcohol, let us say 34 c.c., diluted to a hundred c.c.—that is roughly three ounces of a 34 per cent alcohol—the non-initiated individual, the occasional drinker, will have about that concentration in the blood. However, if you give it to an old toper, you will find that

his concentration in the blood will be far less. It may be half as much.

The reason for this is that repetitious drinking, and the repetitious impinging of particles of alcohol (the constituents of the drink) upon the mucosa of the stomach and intestines, causes it to become indurated, and the alcohol is not absorbed as rapidly.

And this is a condition that is called a pseudo tolerance, not a real tolerance.

But this is the result of the constant effects of the alcohol that he is taking. He is getting the pleasure of drinking, if you can call it pleasure. But he is paying for it. He does not really get much of the effect, but he is simply taking pleasure in drinking it and taking it down the hatch.

DR. FISHER: Here is a question for Dr. Gundry.

Q. Does alcohol increase the physical efficiency of an individual when taken in small calculated amounts?

DR. GUNDRY: No, it does not. I am sorry, but it does not.

All tests that have been done with accuracy, like throwing darts, or playing baseball, or doing anything that requires ordinary physical coordination, even playing tennis, is not done as well when under the influence of alcohol.

People commonly think that they are doing better, because their inhibitions are removed, and they move around with seeming great facility. However, they do not do the tests better.

This has been my observation over many years in treating chronic alcoholic addicts and watching them play pool. You know about how he plays on the average, and then you see him miss two or three easy shots. You wonder what his blood alcohol is. Very often, when checked, it is found to be rather high at that time.

Now, there is another question here. Do you want me to answer that?

DR. FISHER: Yes, go ahead.

Q. DR. GUNDRY: What effect does fatigue have on a person with alcohol in his system?

Well, I think it has about the same effect as on a person without alcohol.

This was observed in the experiments of Bjerber and Goldberg, in which two groups of drivers were exposed to exactly the same amount of fatigue, or boredom, or whatever factor entered, and I think it was shown that the effect was about the same. Very often when you hear a person say that he is tired, I think that it should be spelled differently. Instead of t-i-r-e-d, it ought to be t-i-g-h-t.

DR. FISHER: Here is a question for Mr. Solter.

Q. Do you believe a blood test taken from an unconscious defendant would be admissible in court?

MR. SOLTER: Well, there are cases in other jurisdictions which have held on that question both ways.

That may sound like typical lawyer's answer, but in law you can always find a case somewhere that is opposed to what you want.

It would seem to me that if the test were upheld on the question of self-incrimination, that is, if it could be taken from him when he is aware of what is going on, without violating his constitutional rights, that certainly it would be equally constitutional to do it when he was without his senses. I don't know whether that satisfactorily answers the question or not. But, on the other hand, I think that if it were not constitutional to take it from him while he was aware of it, obviously it would not be the other way.

DR. FISHER: Dr. Krantz, here is one for you.

Q. Would a high blood sugar give a false positive blood alcohol or a higher blood alcohol percentage in the iodine pentoxide starch test?

DR. KRANTZ: No, it would not.

DR. FISHER: That disposes of that.

Here is another one for Dr. Krantz.

Q. If the percentage of alcohol when ingested is known, and the base line time element at the base of your graph, would it not be necessary to know exactly when the driver began to drink his six beers, and to know how long he lingered

at the bar to drink from his first to his sixth beer; and also would you not have to know the time of the accident when the test would be given, and how much time elapsed after the accident before the test was given?

This is a double question, actually, the first having to do with whether you can prophesy a blood level in terms of time spent in drinking it; and the second, what is the effect of delay after the accident on the picture of the individual at the time he had the accident.

DR. KRANTZ: No, you cannot prophesy a blood level in any individual from the amount of alcohol he has ingested, because so many factors are involved.

As has been pointed out this evening, one important factor is how much food is in the stomach during the time of ingestion. This will delay the absorption.

If the alcohol has been ingested in malt beverages, such as beer, or ale, the colloidal matter will retard absorption of the alcohol. The dilution of the alcohol is an important factor. And what is more, every individual will absorb alcohol to a different degree. The absorption of alcohol from the gastro-intestinal tract is absorption very much like through a sieve. It is like a small particle going through a larger opening. And the absorption of certain other materials, like sugar, from the tract is a more definitely regulated process and it involves certain enzymatic reactions. So that the amount of alcohol cannot be predicted in one's blood from the amount of alcohol that has been ingested, unless all the other factors are known. And then it would be nothing more than a speculation, and not an accurate estimation.

Q. DR. FISHER: In other words, it is not so much to know how much he drank or when he drank it, but you would have to go back to some test to show what his blood level was at the time of the accident?

DR. KRANTZ: That would be my opinion.

Q. DR. FISHER: Now, the other part of this question goes into the delay between the accident

and the time the test is taken. And this is an important problem in the use of the test. Can you tell us something about that?

DR. KRANTZ: Well, the test, of course, will give you no indication as to when the alcohol was ingested. It will not tell you whether the curve was on its ascendancy or whether it was on its descendancy, which in turn may make a difference in the symptomatology of the patient. Nevertheless, the test will tell you that he has or has not alcohol in his blood, that will influence the alacrity in his ability to handle various situations.

DR. FISHER: Here is one for Mr. Solter.

Q. The license to drive being a privilege granted by the State, could it not be made a prerequisite in his application to get a driving permit that he agrees in advance that if he is ever accused of drunken driving in the future, he will submit to a chemical test?

MR. SOLTER: I have a feeling I know who thought up that one.

MR. WOLFSON: I have the answer to it.

MR. SOLTER: Of course, that goes back into this whole question that the license to drive an automobile is a privilege granted by the State rather than a right that exists in the individual as a citizen.

It would seem to me that under the present interpretation of licensing, that that condition would be valid, because now, today, even if a man is convicted in the Traffic Court, where the Magistrate has a right to suspend a driver's license up to ninety days for the conviction, the individual is still subject to administrative review of his case by the Commissioner of Motor Vehicles.

And it frequently happens, that even after a man has been sentenced, fined, and his license revoked or suspended, or, rather suspended by the Traffic Court, for the maximum ninety days, he may go before the Commissioner on a hearing and have his license taken up permanently, indefinitely, or for a specific period of time.

So that points up the issue, that it is still looked upon as a privilege rather than a right of the individual.

If it were a right, a lawyer might have a good argument when he went before the Commissioner of Motor Vehicles to claim that his client was being placed in double jeopardy, that he had already been tried and convicted for this offense at the Traffic Court, and his sentence had been meted out, and that any further action would place him in double jeopardy.

Lots of people have argued that, but nobody has ever taken it to the Court of Appeals. And I am not the Court of Appeals, and I do not know what the answer is.

MR. WOLFSON: Well, Mr. Solter, I asked that question.

Now, isn't it true that in civil cases all non-resident drivers in effect subject themselves to having service of summons received for them—and whether they ever get them or not makes no difference—but you send the notice of summons, advising the disposition of the license with respect to the non-resident driver.

MR. SOLTER: That is right.

MR. WOLFSON: Now, they are subject to judgment even if they never come into court, and that procedure is followed even when the registered letter is mailed out.

MR. SOLTER: That is right.

MR. WOLFSON: To follow out along that line, it seems to me that applicants for drivers' licenses could be required by the State, under its Police power, as a condition precedent to the issuance of the license, to agree to submit to an alcohol test if ever requested to do so by proper authority, on the theory that a license to drive is a privilege and not a right.

MR. SOLTER: Well, I think that is a very good analogy.

DR. FISHER: Here is a question that I know there is no answer to. But it has been directed to Dr. Gundry, and I will ask him if he has anything to say on it.

Q. How can one organize a club among doctors entitled "Never Drive Having Drunk?"

DR. GUNDRY: As Dr. Fisher has already pointed out, there is not a simple answer to that question.

Most of the legal profession I am sure know it is very difficult to get more than one or two doctors to agree on a diagnosis.

Doctors are rather rugged individualists. However, I can say for myself, after reading all this literature I am impressed to the point that I will not want to drive when I have had more than one drink. You never know exactly how it is going to affect you. It may be absorbed rapidly, or slowly. Personally I have no desire to get involved in alcohol influence cases, and especially with somebody like the gentleman over here on my right acting as prosecutor.

DR. FISHER: Here is one that has reference to the fact that our Maryland statutes provide for driving while under the influence of intoxicants as well as under the influence of drugs.

I acknowledge that briefly by saying that is true. Yet the problem of driving while under the influence of drugs is almost negligible, in comparison with those persons who drive while under the influence of alcohol.

DR. FISHER: Here is one directed to Dr. Krantz, again getting down to where the chemical test is employed.

This is the doctor's question.

Q. Will the presence of hydroxy butyric acid (as a part of acidosis)—alter the final result in a breathing test?

DR. KRANTZ: I cannot answer that question out of my own experience, except that my opinion would be that the amount of hydroxy butyric acid present on one's breath would not influence the test with regard to the amount of alcohol that is present. This is due to the fact that if alcohol had been ingested, the amount of alcohol would be so much greater than the amount of hydroxy butyric acid that the amount

of hydroxy butyric acid would be negligible as influencing the test, if it did, and I am not sure that it would.

DR. FISHER: This has been confirmed many times, even diabetics of the worst type, taking the chemical test, will show a result of .01 or .02, and we know that we would not accuse them of drunken driving.

DR. FISHER: Here is one that could probably be put to all of you:

Q. Would it be in order for this meeting to pass a resolution endorsing the use of alcoholic tests in drunken driving cases, and send such results to the proper authorities?

Now, I don't know how to answer that question. I am sure that it is in order for every one in here, both the physicians and the lawyers, and the other folks concerned, to work, and to work actively, at the Legislative Council level, and, more importantly, in Annapolis, when the opportunity arises to do something that will improve the way we are handling our drunken driving cases.

We know of some of the things that have happened in the way of handling these "under the influence cases" in other places. And by a vigorous program of enforcement, they can show statistically that they have decreased deaths due to alcoholism.

In the City of Detroit, in a period of less than ten years, they have shown a decrease from ninety a year to ten a year.

If Detroit can do that, Maryland can do something good along this line.

And whether this Act provides for this meeting here to pass a resolution, I do not know, but I am sure it is certainly proper for those of us here who are interested enough to come in here for such a discussion as this to continue to work for improvement in our problems along this line.

I think this rounds out the questions. And if there are no more, I believe the meeting should stand adjourned.

ARTICLES OF INTEREST

PRESENTATION OF THE SCHERING AWARD TO IRVIN P. POLLACK

A sophomore medical student at the University of Maryland School of Medicine received a check for \$500 as first prize winner of the 1953 Schering Award. Mr. J. Roger Cox, the mid-Atlantic supervisor of this firm, presented the award to Mr. Irvin P. Pollack, and Dr. H. Boyd Wylie, Dean of the Medical School, participated in the ceremony.

Mr. Pollack wrote on the "New Concepts in the Treatment of Peptic Ulcer." He is a graduate of the Baltimore City College and The Johns Hopkins University.



Mr. J. Roger Cox, Mr. Irvin P. Pollack and Dr. H. Boyd Wylie

REPORT OF THE JOINT COMMITTEE ON DISEASES OF THE CHEST

At the request of Dr. Webster H. Brown and Dr. Otto C. Brantigan, State Officers of the American College of Radiology and the American College of Chest Physicians, the following report is published so that all our members may be familiar with it:

PURPOSE OF JOINT COMMITTEE ON DISEASES OF THE CHEST

In establishing a Joint Committee on Diseases of the Chest, the purpose of the American College of Chest Physicians and

the American College of Radiology is to exchange ideas and to propose guiding principles on the problems involved in routine chest x-rays in hospitals (general, mental, etc.), and mass chest x-ray programs. The committee agrees: that each physician should be encouraged to have a chest x-ray on all of his patients; that every patient admitted to a hospital, private or public, should have a routine chest x-ray; and that the follow-up for all suspected lesions seen in chest x-ray surveys should be organized very carefully to assure that the patient comes under medical supervision.

LIMITS OF SURVEY

Routine chest x-ray examinations should be defined as those examinations of the chest which are conducted to screen persons with abnormal changes of the chest from persons with normal chests. The examinations are screening diagnostic procedures and are not to be considered as clinical diagnostic examinations. The screening method is for the purpose of detecting the presence or absence of a lesion only.

The size of the film which one uses for screening purposes is not of primary importance. The committee believes in principle, however, that when microfilms have been used, a 14" x 17" film is a necessary second step in the screening procedure and the mechanism whereby such is provided in any community shall be determined by the local medical society or the local hospital staff. Survey chest x-rays either in hospitals or in the general population are approved as a screening device if conducted by agencies which utilize well qualified professional and technical personnel and which make sincere efforts to send the positive individuals to qualified local physicians or clinics for proper follow-up.

INTERPRETATION AND REPORT

Interpretation and reporting of medical findings is a medical matter and should bear the signature or identification of the responsible physician.

METHOD OF REPORTING

Method of reporting of chest survey studies: This is a local matter and is by prearranged agreement between the employer and the employee in industrial surveys; in other surveys is in accord with medical ethics, according to local agreement.

TYPE OF REPORTING

Type of reporting: The committee discourages the reporting of suspicious cases as tuberculosis. It believes this to be a clinical diagnosis. The x-ray interpreter should designate the cases that require immediate follow-up as "urgent." The small film x-ray interpretation is merely an impression.

It should be emphasized that the 14" x 17" film is a diagnostic aid and the results derived therefrom are also impressions and not diagnoses. Even the larger film is but one of

several examinations necessary in order to establish correct diagnoses.

DOUBLE READING

The committee notes the several publications indicating the extent of false negative and false positive reports resulting from inter- and intra-individual variations in interpretations of chest films. From these it is evident that failures to detect tuberculosis can be reduced by multiple readings, but at the expense of increasing the false positives, unless a check mechanism is employed. The simplest elaboration of multiple reading is the independent interpretation of the film by two physicians with referee conference of the two undertaken in those cases in which they disagree. Only those cases on which both agree in conference should be followed.

While such a procedure may result in the detection of a slightly larger portion of all the abnormal cases, it may not be feasible from an economic or personnel standpoint. Groups responsible for survey operations are urged by the committee to give consideration to double reading as one of the methods by which survey yields may be increased. Availability of financial resources and qualified professional personnel, as well as the need for other services of relative importance, will be determinates in this decision. The committee, therefore, calls attention to some of the virtues of double reading but does not recommend it unreservedly.

PROFESSIONAL COMPENSATION

The professional cost of performing routine chest examinations in hospitals: The Joint Committee believes the radiologist and/or chest physician should be compensated just as any other physician practicing his profession. The procedure is time consuming and places a definite responsibility on the radiologist or chest physician. The committee likewise felt that in this matter the basic principle of payment is by arrangement between the physician and the hospital or agency involved. In the reading of follow-up films there should also be an individual limit to the number of films which should be read in any one day by one physician and which he should not exceed. The compensation, of course, would have to take into consideration whether the physician makes the film in addition to interpreting it.

CLOTHING OF PATIENTS

Whether or not a screening examination can be conducted with the patient fully clothed: Since the number of lesions overlooked because of clothing (2%) is considerably smaller than the normal variations of interpretation demonstrated to exist in the reading of photofluorographic films, it is concluded that the examination of clothed persons is as effective a procedure as examination of the undressed persons. Since examination of the fully clothed persons is an easier procedure as compared

with the examination of the undressed persons, the committee agreed that screening examination may be conducted with the patient fully clothed.

READERS' QUALIFICATIONS

Qualifications of readers in mass chest surveys: It was believed at the present time there was no practical method which could be used to evaluate the qualifications of a particular reader. Studies in this respect are being made at the present time. It is hoped that within a short period of time satisfactory testing methods will be available. The committee therefore agreed to leave this matter open for further discussion.

PROTECTION

The radiation received by all professional, technical and clerical personnel associated with photofluorographic equipment should be continuously monitored by means of film badges or other devices which have been proved to be satisfactory for determining the radiation exposure of personnel.

When an individual receives more than 100 milliroentgens per week, the medical officer in charge of the unit should immediately determine whether the individual has been careless or whether the protective devices of the equipment are at fault.

If the fault lies with the individual, the individual should be informed of the fact and strongly cautioned regarding the dangers of excessive radiation exposure. Failure to regard such warning should be considered as negligence on the part of the individual.

If the fault lies with the equipment or protective devices, the photofluorographic unit should immediately be taken out of commission until such time that measurements of radiation conditions where technical or clerical personnel are required to work will yield radiation exposures less than 100 milliroentgens per week for case loads of 2500 exposures at 95 kv. and 40 ma. seconds (the average exposure per photofluorographic chest film).

CONTINUATION OF STUDY

It is recommended that the Joint Committee arrangement continue and that the Joint Committee meet annually, or at the call of the co-chairmen. In an effort to have the Joint Committee act continuously and without interruption, interim ideas should be sent to the co-chairmen, and an exchange of opinion should continue during the intervals between meetings. Recommendations are solicited from all interested in the affairs of the Joint Committee.

Respectfully submitted,
LEO G. RIGLER, M.D.
OTTO L. BETTAG, M.D.
Co-Chairmen, Joint Committee
on Diseases of the Chest

Component Medical Societies

BALTIMORE CITY MEDICAL SOCIETY

CONRAD ACTON, M.D.

Journal Representative

As this goes to press the State Meeting is ending. It has been a splendid meeting. The instructions to the City Delegates concerning the Building Fund Assessment were kept. The sentiments of the meeting were such that passage of the resolution seemed assured in any event. Palms to Doctor Goldstein.

The City Society Constitution changes our regular Meeting date to the FIRST Friday in each month. (It has been the third Friday). We were all aware of this when the Constitution was read and passed. It was not until the program for the State Medical Meeting put it in print that the reality of the change of custom was realized by many. The new program date: FIRST Friday, should be kept in mind.

The General Practice Section of the City Society is having an organization meeting in May. Copy for this issue goes in too soon to hazard any predictions about what will occur. This Section organization is in accord with developments all along the line.

The Executive *Committee* differs from the Executive *Board*, whose membership is as stated in the new Constitution. The Committee consists of the *elected* officers of our Society and passes on matters that have to do with the actual business of running it. The Executive *Committee* is meeting about every two weeks now, and considers a large number of matters that are brought before it, and it screens applications for membership and carries out the voted mandates of meetings. The Executive *Board* meets on the third Tuesday of each month and is concerned more prominently with policy formulation and matters of inter-society as well as intra-society importance.

BALTIMORE COUNTY MEDICAL ASSOCIATION

SAMUEL P. SCALIA, M.D.

Journal Representative

The Sheppard Pratt Hospital in Towson was the scene of the April luncheon meeting of the Balti-

more County Medical Association. The meeting was held Wednesday, April 21, 1954.

Dr. S. P. Scalia gave a report on the recent meeting of JOURNAL Representatives held at the Faculty Building. The Society welcomed the opportunity of devoting one issue of the JOURNAL to Baltimore County. We have promises of several scientific articles, but are anxious to accept more. The JOURNAL is especially interested in some historical material concerning Baltimore County and the medical society. If any readers have any such materials, please contact the writer. Pictures are particularly desirable.

Quite a discussion was raised by the proposed yearly registration of all Maryland physicians as suggested by the JOURNAL Representatives group. It seems that there is no current roster of active physicians in the State of Maryland. The Narcotics Bureau and the County Clerk cannot disclose their listings. Therefore, no one knows what the physician census of Maryland is. This problem is to be discussed at the House of Delegates meeting.

The scientific portion of the program was presented by Dr. Raymond Band, a member of the resident house staff. He read a paper entitled, "Recovery from an Acute Psychosis Following a Coronary Thrombosis." The paper was well received by the membership present.

CARROLL COUNTY MEDICAL SOCIETY

WILLIAM L. STEWART, M.D.

Journal Representative

At a recent meeting a committee consisting of Drs. Foutz, Bare, and Jennette was appointed to determine whether or not an emergency medical call system is needed in Carroll County.

Dr. Werbner recently associated with the Springfield State Hospital at Sykesville was welcomed into the Society.

Our guest speaker was Dr. John Young, a former Carroll Countian, who is now practicing urology in Baltimore. Dr. Young gave us a very interesting talk on hematuria and its causes, frequency in the

female and its frequent cure by repeated urethral dilations, and the relation of enuresis in children to congenital anomalies. His lecture was made even more enlightening by the x-rays he brought along showing the various conditions of which he spoke.

DORCHESTER COUNTY MEDICAL SOCIETY

ALFRED R. MARYANOV, M.D.

Journal Representative

Four years ago, the members of the Dorchester County Medical Society voted to have all monthly meetings at the homes of the various members, proceeding alphabetically down our roster. This has worked quite successfully, and all of the meetings have been very well attended. At the present time all of our monthly meetings are attended by better than ninety per cent of the members of this Society.

The March meeting of this society was held at the home of Dr. Walter B. Johnson on March 18, 1954. The speaker for the evening was Dr. Eugene Traub, Professor of Dermatology of New York Medical College. His topic was Common Dermatoses, which was illustrated by lantern slides. Dr. Traub maintains his home in the vicinity of Cambridge, and is present in this community from Thursday to Monday. The local members of our Society have made use of Dr. Traub's knowledge of his specialty, and at the present time Dr. Traub conducts a Dermatology Clinic at the Cambridge Maryland Hospital once monthly.

HARFORD COUNTY MEDICAL SOCIETY

FREDERICK J. HATEM, M.D.

Journal Representative

The March meeting was held at Dr. Horky's home, and buffet luncheon was served. Dr. Frank Ayd of Baltimore spoke on "Physical Methods in Psychiatry," and described the present status of shock therapy, lobotomy, and treatment with new drugs.

Members present were: Doctors Barthel, Brendel, Dolce, Dorogi, Finney, Hall, Hatem, Hodous, Horky, Marek, Palmer, Phillips, Rodman, Sandeck, and Stonesifer.

Old business:

Woman's Auxiliary—meeting to be arranged with representatives of Baltimore City group and some local wives.

New business:

1. Faculty building assessment. The delegate, Dr. Rodman, to attend discussion uninstructed.

2. Adoption law. Dr. Horky to attend meeting. Harford County Medical Society considers law needs revision.

3. Secretary-Treasurer—Dr. Hatem elected to replace Dr. Hayman who resigned to accept position of Assistant Director of Public Health of the Territory of Alaska.

WASHINGTON COUNTY MEDICAL SOCIETY

SIDNEY NOVENSTEIN, M.D.

Journal Representative

The Spring meeting of the Medical Society of Washington County was held at the Alexander Hotel April 15th, 1954 at 6:00 p.m., Dr. Archie R. Cohen presiding. The following was the agenda:

SCIENTIFIC SPEAKERS

Public Relations

Mr. Robert L. Richards, Staff Secretary of the Committee of Public Relations of the Medical Society of the State of Pennsylvania and Dr. Allen W. Cowley, Chairman of the Committee of Public Relations of the Medical Society of the State of Pennsylvania spoke of the need for more public relations and it was emphasized that a good Public Relations Program should consist of six (6) points:

1. Provide an adequate emergency call service.
2. Create a grievance or mediation committee.
3. Maintain a speakers' bureau supplemented by other health education activities.
4. Establish good working relations with the press, radio, television and other publicity media.
5. Build leadership among society members in county or area with all voluntary and governmental health organizations.
6. Prepare and use all available means to actively encourage every family to secure the services of a family physician.



Courtesy of The Hagerstown Daily Mail

Standing, from left to right: Dr. Ernest Poole, Dr. Archie R. Cohen, Dr. B. B. Kneisley, Dr. L. Stephen Noel, and Dr. S. Earl Young. Seated left to right: Dr. Allen W. Cowley and Mr. Robert L. Richards.

GUESTS

Guests of the Medical Society were Washington County Dental Society and members of the Board of Trustees of the Washington County Hospital.

EXHIBITS

Various local companies presented exhibits of modern business procedures and techniques.

BUSINESS

The delegate to the annual meeting of the Medical and Chirurgical Faculty was instructed to approve the following resolutions:

1. To assess members of the State Society on the following basis (Baltimore City members \$150.00; County members \$100.00, payable

over the next ten years), in order to raise funds for the new faculty building.

2. Proposed changes in the Constitution.

It was announced that the invitation of the Washington County Medical Society to the Medical and Chirurgical Faculty was accepted and therefore the semiannual meeting of the State Society will be held in Hagerstown in the fall of 1954.

Report by Dr. O. D. Sprecher, Chairman of the Committee to investigate feasibility of Washington County Medical Society taking charge of one issue of the JOURNAL was given and the Committee felt that it would be impossible to do so because of the lack of material, therefore the Society vetoed any such undertaking.

WOULD YOU LIKE AN INTERESTING PAMPHLET?

"Medical Research May Save Your Life!"

This pamphlet tells the dramatic story of what medical research and medical care have meant to all Americans. The price is 25¢ per copy, but if bought in quantity are less expensive. If you wish a pamphlet or additional information write to Lura Street Jackson, Public Affairs Pamphlets, 22 East 38th Street, New York 16, New York.

Library

"Books shall be thy companions; bookcases and shelves, thy pleasure-nooks and gardens." *ibn Tibbon*

HYPERTENSION

LOUIS KRAUSE, M.D.*

"Man is as old as his arteries" was said by the ancients, particularly in the pre-Christian era in Greece. Today, we know very little more about arteries than those folks did at that time. We still are stressing a physical finding and rarely do we relate it to an etiological cause. Save for the few reversible surgical conditions causing hypertension, the isolated instance of psychosomatic hypertension, the minority helped by diet, our remedies are far from satisfactory. Perhaps we are in a comparable position in this century as the doctors were in the last century in regard to fever. Conditions were called intermittent fever, continuous fever, remittent fever, etc, etiology entirely unknown. At this time we are calling hypertension frequently according to its rapidity of development, the height of it and whether it is fluctuating, benign and malignant, etc.

To cover the story of vascular diseases and hypertension is impossible, but to get a bird's eye view of the theories and the many remedies offered, one needs just to glance over the following list. It is apparent immediately that where the fundamental truths are unknown, theories multiply.

The following books on "Hypertension" may be borrowed from the Library:

- Allen, F. M. Treatment of kidney diseases and high blood pressure. Morristown, Physiatric Institute, 1925.
- Bechgaard, P. and Hammarström, S. Surgical treatment of arterial hypertension. Copenhagen, Danish Science Press, 1950. (*Acta Chirurgica Scandinavica*, Supplement 155)
- Binger, C. A. L., and others. Personality in arterial hypertension. N. Y., Pub. with the sponsorship of the American Society for Research in Psychosomatic Problems, 1945.
- Crile, G. W. The surgical treatment of hypertension. Phila., Saunders, 1938.

* Chairman, Library Committee.

- Dally, J. F. H. High blood pressure, its variations and control. N. Y., W. Wood, 1924.
- Fishberg, A. M. Hypertension and nephritis. 4th. ed. Phila., Lea & Febiger, 1939.
- Gager, L. T. Hypertension. Balto., Williams & Wilkins, 1930.
- Gladstone, S. A. Cardiac output and arterial hypertension. N. Y., n. p., 1935.
- Goldblatt, H. The renal origin of hypertension. Springfield, Thomas, 1948.
- Goldring, W., and Chasis, H. Hypertension and hypertensive disease. N. Y., Commonwealth Fund, 1944.
- Gunewardene, H. O., High blood pressure and its common sequelae. London, Baillière, Tindall & Cox, 1935.
- Harrower, H. R. The hepatic principle, anabolin, detoxication by the liver and the control of functional hypertension. London, Baillière, Tindall & Cox, 1927.
- Hypertension; a symposium held at the University of Minnesota on September 18, 19, 20, 1950, in honor of Elexious T. Bell, Benjamin J. Clawson, and George E. Fahr. Minneapolis, University of Minnesota Press, 1951.
- Page, I. H., and Corcoran, A. C. Arterial hypertension, its diagnosis and treatment. Chicago, Yearbook, 1945.
- Rømcke, O. Der Blutzucker im älteren Alter, insbesondere bei hypertensischen Zuständen. Oslo, Nationaltrykkeriet, 1931. (*Acta medica Scandinavica*, Supplement 39).
- Russell, W. Arterial hypertonus, sclerosis and blood-pressure. Phila., Lippincott, 1908.
- Schroeder, H. A., Hypertensive diseases. Phila., Lea & Febiger, 1953.
- Shaw, H. B. Hyperpiesia and hyperpiesis (hypertension), a clinical, pathological and experimental study. London, H. Frowde, 1922.
- Stieglitz, E. J. Abnormal arterial tension. N. Y., National Medical Book Co., 1935.
- Stieglitz, E. J. Arterial hypertension. N. Y., P. B. Hoeber, 1930.
- Stone, W. J. Bright's disease and arterial hypertension. Phila., Saunders, 1936.

Warfield, L. M. Arteriosclerosis and hypertension with chapters on blood pressure. 3rd ed. St. Louis, Mosby, 1920.

SUMMARY OF LIBRARY ACTIVITIES IN 1953

The attached statistical report falls far short of giving a true picture of the library activities. The new staff were too busy trying to familiarize themselves with the library and serving patrons to record the statistics.

With the resignation of Mrs. Eleanor Kohler, effective September 30th, and the coming of Miss Myrtle Hollins in her place, the entire library staff with the exception of Mrs. Ella Chatt, janitress and stack assistant, was new since November 1, 1952. Unfamiliarity with what had gone before has been a great handicap.

Some highlights of the year in the library follow.

1. SERVICES.

a. Reference work (much of it by telephone)

Supplying names, addresses, etc. of doctors from our directories.

Verifying references, including long bibliographies.

Compiling bibliographies.

Looking up material on hundreds of such varied subjects as hyperthyroid disease and pregnancy, prolapsed placenta, spontaneous pneumothorax, lymphosarcoma of nose or paranasal sinuses, technique of sympathectomy and of subtotal adrenalectomy for hypertension, parathyroid tumors in superior mediastinum, articles written by some 30 staff members of Spring Grove Hospital during their tenure there, history of various county medical societies, etc., etc.

Locating specific articles, with very little information to go on.

Assembling information and material for the exhibit on "300 years of Maryland Medicine" held at the Maryland Historical Society.

b. Getting out material for use in the library or for home use; checking the latter in and out, and replacing material on shelves.

c. Mailing material to members throughout the state.

d. Behind the scenes preparation of material, which includes checking against card catalog or periodical record for duplication, accessioning, classifying and cataloging, plating, stamping, marking, etc.

e. Borrowing from and lending to other libraries.

f. Distributing duplicate books and journals to younger libraries in the city, and to other libraries throughout the world through the Medical Library Association Exchange.

g. Contributing book lists and library notes for each issue of the Maryland State Medical Journal, and compiling indexes to the 1952 and 1953 volumes of the Journal.

2. REORGANIZATION.

a. Reclassification and recataloging of 2,237 volumes, mostly recent books, has made them much easier to find and put away.

b. Open shelves have been installed in the Reading Room and will make many more recent books accessible to readers.

c. Glass-doored cases in Reading Room are now used to protect and display some of our valuable old books, now housed in the stacks.

d. The Periodical Room and the Librarian's Office were air-conditioned last summer, to the benefit of both patrons and staff.

e. Periodical subscriptions have been placed in the hands of an agent, in accordance with usual library practice. This saves money, time, and bookkeeping.

f. Visible record equipment has been purchased to consolidate the five former periodical record files into one, in the interest of efficiency.

g. Other new equipment has been purchased, including filing cabinets, book ends, an additional book truck, a postal scale, a bulletin board, etc., and has speeded up the work.

h. Space is being made in the basement, where heretofore only duplicates have been kept, for expansion of our original periodical collection, which is overflowing stacks 1 and 2. Removal of extra copies of Faculty publications to storage outside the building has released much-needed space for this purpose.

3. PLANS FOR 1954 include:

- a. More aggressive policy for purchase of new books.
- b. Better care of valuable old books and leather bindings.

The fine spirit of cooperation of all members of the library staff—Mrs. Henry Berge, Miss Myrtle Hollins, and Mrs. Ella Chatt—has been noteworthy.

THIS IS YOUR LIBRARY. YOUR SUGGESTIONS WILL BE WELCOMED.

Helen Wheeler, A.B., B.S.,
LIBRARIAN.

LIBRARY REPORT

January to December, 1953

CIRCULATION AND ATTENDANCE.

Circulated books.....	3,623
Books used in Library.....	3,858
Total.....	7,481
Total volumes in 1952.....	76,298
Books added, 1953.....	676
Journals added, 1953.....	446
Total volumes in Library.....	77,420
Attendance.....	3,118

MEDICAL LIBRARY ASSOCIATION

Issues sent on exchange.....	2,275
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BINDING

Journals bound.....	583
Total cost.....	\$1,843.65
Average cost per journal.....	\$ 3.16

COUNTY MEMBERS

Requests filled.....	239
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GIFTS

Unbound journals.....	7,608
Bound journals.....	348
Books.....	1,248
Reports and pamphlets.....	105
Reprints.....	1,794
Pictures.....	2
Diploma.....	1
Museum pieces.....	1 case
Total.....	11,107

RECLASSIFICATION AND CATALOGING

Volumes processed.....	2,237
Volumes withdrawn.....	12

INTER-LIBRARY LOANS

Loaned

Army Chemical Center.....	1
Baltimore City Health Dept.....	5
Bon Secours Hosp.....	1
Ft. Howard Hosp. Lib.....	21
Johns Hopkins Univ.....	6
Lehigh Univ.....	1
Loyola College.....	2
Medical College of S. C.....	1
Mercy Hosp.....	2
Notre Dame College.....	3
Pratt Library.....	1
St. Joseph's Hosp.....	40
Seton Institute.....	2
Sheppard Pratt Hosp.....	13
Sinai Hosp.....	31
Social Security Lib.....	11
U. S. Army Lib. (Ft. Meade).....	2
U. S. Dept. Agriculture.....	1
U. S. Pub. Health Hosp.....	797
U. S. Vet. Admin. Hosp.....	1
Univ. Maryland.....	4
Welch Med. Lib.....	74
Wilmer Institute.....	8
Total.....	1,028

Borrowed

Armed Forces Med. Lib.....	6
Sheppard Pratt Hosp.....	1
U. S. Pub. H. Hosp.....	1
University of Md.....	36
Univ. Minn. Farm Lib.....	1
Welch Med. Lib.....	32
Western Reserve Univ.....	1
Wilmer Institute.....	2
Total.....	80

PETTY CASH REPORT

Balance on hand Dec. 31, 1952.....	\$5.00
Received from office and refunds on express and postage, etc.....	156.50
Total.....	\$161.50
Expenses.....	136.68
Balance on hand, December 31, 1953.....	\$ 24.82

Health Departments

STATE OF MARYLAND DEPARTMENT OF HEALTH MONTHLY COMMUNICABLE DISEASE REPORT Case Reports Received during 4-week Period, April 30-May 27, 1954

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCUS	MUMPS	POLIOHEPATIC, PARALYTIC	POLIOHEPATIC, NON-PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS
																			Influenza and pneumonia
Total, 4 weeks																			
Local areas																			
Baltimore County.....	33	—	8	4	359	—	95	1	—	—	35	—	—	7	16	1	7	e-2	2
Anne Arundel.....	10	—	—	—	113	—	9	—	—	1	2	—	—	—	13	—	1	e-3	—
Howard.....	—	—	—	—	13	—	5	—	—	—	—	—	—	2	1	1	—	—	—
Harford.....	2	—	4	12	55	—	6	—	—	—	2	—	—	—	3	—	—	—	1
Carroll.....	2	—	1	—	19	—	—	—	—	—	21	—	—	—	2	—	—	—	—
Frederick.....	16	—	—	19	16	—	2	—	—	—	—	—	—	—	2	—	1	—	2
Washington.....	3	—	—	4	1	—	16	—	—	—	—	—	—	5	3	—	2	—	1
Allegany.....	—	—	—	3	4	—	5	—	—	—	9	—	—	2	1	—	1	—	3
Garrett.....	—	—	—	—	2	—	1	—	—	—	2	1	—	1	—	—	—	—	—
Montgomery.....	32	—	13	12	288	—	48	—	—	—	8	—	1	—	9	—	2	e-4	3
Prince George's.....	20	—	5	2	213	1	28	—	—	—	8	—	—	4	6	—	1	e-1	—
Calvert.....	2	—	—	3	1	—	1	—	—	1	—	—	—	—	1	—	—	—	—
Charles.....	4	—	—	—	—	—	1	—	—	—	2	—	—	—	—	2	—	—	—
Saint Mary's.....	3	—	—	—	41	—	2	—	—	—	2	—	—	—	—	—	1	—	1
Cecil.....	2	—	1	6	9	—	1	—	—	—	—	—	—	—	2	—	3	—	1
Kent.....	16	—	—	3	14	—	7	—	—	—	—	—	—	—	—	—	—	—	—
Queen Anne's.....	—	—	1	1	4	—	—	—	—	—	—	—	1	—	2	—	—	—	—
Caroline.....	—	—	—	—	7	—	—	—	—	—	—	—	—	2	1	—	5	—	—
Talbot.....	—	—	—	—	1	—	—	—	—	—	—	—	—	4	1	—	—	—	1
Dorchester.....	2	—	3	—	30	—	1	—	—	1	—	—	—	—	5	2	10	—	2
Wicomico.....	15	—	—	—	1	—	14	—	—	—	4	—	—	—	2	—	15	—	—
Worcester.....	4	—	1	—	67	—	—	—	—	—	1	1	—	7	1	—	—	—	—
Somerset.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	5	—	—
Total Counties.....	166	0	37	69	1258	1	242	1	0	3	96	2	2	34	71	6	54		17
Baltimore City.....	138	0	11	5	616	2	138	0	0	2	78	0	0	34	96	4	572		14
State																			
Apr. 30-May 27, '54..	304	0	48	74	1874	3	380	1	0	5	174	2	2	68	167	10	626		31
Same period 1953.....	314	1	340	31	420	0	467	3	0	2	391	0	3	8	190	9	620		27
5-year median.....	465	1	218	—	610	4	252	3		3	110	2	3	31	238	37	521		39
Cumulative totals																			
State																			
Year 1954 to date.....	2656	6	213	468	9978	23	2148	4	0	5	1116	6	3	358	884	74	2937		282
Same period 1953.....	2480	8	1289	181	947	45	1357	4	0	2	1965	8	5	80	988	64	3137		431
5-year median.....	2593	18	775	—	3615	32	1098	11		4	749	9	15	194	1143	212	2709		331

e = encephalitis due to measles and mumps.

1 case of psittacosis was received from Montgomery County.

BALTIMORE CITY HEALTH DEPARTMENT

THE BALTIMORE CITY HOME INSPECTION PROGRAM

LET'S PREVENT THAT HOME ACCIDENT



Sponsored by THE BALTIMORE CITY HEALTH DEPARTMENT and THE BALTIMORE SAFETY COUNCIL

In Cooperation with the Schools of Baltimore City

DEAR PARENTS:

Accidents in the homes of Baltimore during the last five years resulted in more deaths than motor vehicle accidents, and many thousands more suffered serious disability as a result of carelessness. Accidents may strike at any time, in any place, even in YOUR home -- unless the causes are recognized and steps taken to eliminate them.

Can you or any one in your family afford to lose an arm, leg or sight, or even life itself? A few minutes of your time NOW, may spare needless suffering and expense. All we are asking is that you go through your home and look for the hazards indicated below. Get rid of any you find and resolve to change any accident-causing habits the family may have.

When the inspection is over and all the answers have been placed in the boxes under "YES or NO", detach the Answer Column and return it to the school, UNSIGNED. In this way you will help us to learn which hazards are most common in the homes of the community.

Thank you for joining your neighbors and schools in trying to make ours a safer city in which to live.

Sincerely yours,

Commissioner of Health

May, 1954

HOME SAFETY HAZARDS

ANSWER COLUMN

IN THE KITCHEN:

1. Do you keep lye, bleaches, cleaning fluids, rat and bug killers and matches out of reach of small children?
2. Do you keep all electrical equipment in good repair, discarding worn cords, broken plugs or switches?
3. Do you keep containers of hot food and liquids in the center of the table, and pot handles on the stove turned in out of children's reach?
4. Do you wash sharp knives separately and keep them and other sharp or pointed instruments out of children's reach?
5. Do you immediately clean up any spilled food, grease or liquid to prevent falls?
6. Are curtains, shelf coverings and drying laundry kept away from the stove so they cannot catch fire?

IN YOUR BATHROOM:

7. Are all medicines kept out of the children's reach, labelled clearly, and destroyed when no longer in use?
8. Do you avoid touching electric switches, sockets and appliances while any part of your body or clothing is moist?
9. Do you stay in the bathroom with small children to prevent their being drowned or scalded?
10. Is there a non-slip mat or heavy towel for the bottom of the bathtub to prevent falls?

HOW ABOUT THE BEDROOM?

11. Is there a light of some kind near the bed or the door so you need not walk or stumble in the dark?
12. Do you enforce the rule "NO SMOKING IN BED"?
13. Are all windows securely screened and fastened, and beds placed so that children cannot roll, bounce or climb out?
14. Do you keep pins, needles, scissors, and buttons in a sewing box high out of reach of small children?
15. Have you made sure paint on baby's crib and other furniture, window sills and other woodwork does not contain lead?

GENERAL LIVING AREAS:

16. Do you always use a strong, steady step-stool or ladder when trying to reach high places?
17. Are stairs and rails in good repair, adequately lighted, and kept free of all articles to avoid falls?
18. Do all small rugs and mats have non-slip backing or pads under them?
19. Are toys put away after play so that members of the family will not trip or fall over them?
20. Do you protect small children by the use of stairgates and a play pen?

IN THE BASEMENT AND YARD:

21. Is the heating unit or furnace in good repair, and the flues and chimneys tight and clean?
22. Are paints, varnishes, turpentine, etc., kept in tightly covered containers and out of the reach of children?
23. Do you get rid of oily rags, old papers and other trash promptly?
24. When you use cleaning fluids do you allow adequate ventilation and keep away from open flames?
25. Are all tools and garden equipment properly stored where people cannot fall over them or bump into them, and where children cannot get at them?

Check

YES NO

1 () ()

2 () ()

3 () ()

4 () ()

5 () ()

6 () ()

7 () ()

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11 () ()

12 () ()

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25 () ()

TEAR OFF HERE AND RETURN TO THE TEACHER

"Learn To Do Your Part In The Prevention Of Home Accidents"

(See explanation by Dr. Williams on next page)

*(Baltimore City Health Department, continued)***Prevent That Accident!**

Among the leading causes of death in the year 1953, accidents constituted one of the most preventable categories. Of 502 fatal accidents from all causes among residents of Baltimore City, 159 took place in the home, 168 were motor vehicle accidents, 39 were from occupational causes and 136 were in the miscellaneous "other public" category. Aware of the high prevalence of home accidents, the City Health Department last month joined with the Department of Education and the Baltimore Safety Council in a program designed to aid in producing a community appreciation of potential accident hazards in the home. This program was one in which school children were asked to take home a prepared letter and check-list for study with their parents. In a two-weeks period approximately 150,000 letters and check-lists were distributed.

Physicians can do much in disseminating in-

formation and interest in the prevention of accidents, most of which are due to carelessness, both in and out of the home. Accidents are now a leading cause of death. The physician is often in an advantageous position to discuss home safety practices, not only when called upon to treat an accidental injury, but also at other times as well. It is the hope of the Baltimore City Health Department that physicians will join the growing army of accident-preventers and help to teach the lessons the public needs to learn.

The circular letter to parents, shown on the opposite page, will be of interest and value in such efforts.

Huntington Williams, M.D.

Commissioner of Health

HARVARD SCHOOL OF PUBLIC HEALTH

Boston:—The Harvard School of Public Health will give postgraduate scholarships in amounts ranging up to \$5,000 to qualified candidates desiring to study at the School during the academic year 1954-56.

Eligible for Harvard School of Public Health Postgraduate Scholarships are:

1. Physicians, Dentists and Veterinarians interested in preventive medicine and seeking training in one or more Public Health specialties leading to either a Master of Public Health or Doctor of Public Health degree;
2. Industrial Physicians seeking training in Industrial Medicine leading to a Master of Industrial Health degree;
3. Public Health Nurses with a college degree and satisfactory field experience who wish additional Public Health training leading to a Master of Public Health degree;
4. Public Health Engineers seeking additional training and research experience in one or more Public Health specialties leading to either a Master of Science in Hygiene or Doctor of Science in Hygiene degree;
5. College Graduates with academic experience in the natural sciences who desire training and research experience in one of the sciences related to Public Health and leading to either a Master of Science in Hygiene or Doctor of Science in Hygiene degree.

Deadline for filing Scholarship applications is April 30, 1954. Scholarship winners will be announced June 1, 1954.

Application for further information about the Harvard School of Public Health Postgraduate Scholarships may be obtained by writing the Secretary, Harvard School of Public Health, 55 Shattuck Street, Boston 15, Massachusetts.

For more information, call: David S. Davies, Harvard School of Public Health, Telephone: LOnghood 6-2380, Ext. 117 or 118.



Blue Cross - Blue Shield



NATIONAL ADVERTISING

R. H. DABNEY*

This past April, the 84 Blue Cross Plans and the 77 Blue Shield Plans, convinced that their common problems required a vigorous new approach on a broad national scale, launched jointly a nationwide program for public information and education. Although local programs, tailored to fit local needs, had demonstrated their effectiveness in the past, no such joint effort had ever been adopted.

By now, a national audience of some 71,000,000 people is well acquainted with the dignified, yet compelling, messages appearing regularly in *Life*, *Look* and the *Saturday Evening Post*. People who before knew little or nothing of the distinct advantages offered through membership in Blue Cross and Blue Shield are now becoming increasingly aware that they, too, should have the valuable protection which millions in their own communities have acquired.

Anyone who has been connected with the actual administration of the Blue Cross and Blue Shield Plans can readily appreciate the need for an organized and a systematic approach to the public market place. The problems have always been close at hand. It is conceivable, though, that other people, particularly people in the hospital field and in the medical profession, may not be as fully aware of the real reasons behind this new national program.

Principally, there are five significant problems which have confronted all Blue Cross and Blue Shield Plans. It is essential to know what these problems are—why they are problems—to understand the need, *now*, for concerted public information and education. And it is equally important to know that these problems have grown more acute, not less so, despite the tremendous growth in membership and the excellent service to subscribers.

(1) After enrolling 46 millions under Blue Cross and 29 millions under Blue Shield, it is evident that

new enrollments are becoming increasingly difficult and expensive to secure. Most of the larger organizations have already bought some type of coverage. The smaller urban and rural groups, where the need for protection is great, lag far behind.

(2) Despite tremendous growth and unequalled service, all Blue Cross and Blue Shield organizations are finding that cancellations—resulting when people change jobs, when subscribers pinch pennies, and when commercial carriers move vigorously into new areas—are biting dangerously into total memberships, even offsetting fresh enrollments in some localities.

(3) Commercial companies, experienced in selling other kinds of insurance, have entered the field of hospitalization and surgical coverage in force. Their broad advertising programs, almost unrebuted by the Blue Cross and the Blue Shield Plans, have stimulated their success.

(4) Too many Blue Cross and Blue Shield subscribers have become confused about the real purposes and advantages of their own memberships under constant pressure of conflicting commercial advertising. In fact, in many areas the true identities of Blue Cross and Blue Shield Plans have been obscured through the use of similar names and terms by commercial companies.

(5) Finally, numerous human and economic factors have worked to create a popular groundswell for some kind of hospital and medical-surgical protection. People want it; they feel that they are entitled to it. If their wants are not satisfied, such a strong social urge could easily ripen into a general demand for governmental intervention—at any cost.

These, briefly, are the problems which in themselves indicate clearly the objectives for this new joint approach to national information and education. Call it advertising if you will, but practically speaking, "advertising" only describes the media to be used, *not the purposes to be achieved*: (a) To inform and to educate the public, subscribers or not,

* Executive Director, Maryland Hospital Service, Inc.; Maryland Medical Service, Inc.

about benefits; (b) To report, in the institutional sense, upon the progress of Blue Cross and Blue Shield Plans; (c) To bring more and more subscribers into the programs; (d) To convince present subscribers that they should keep their memberships active; (e) To give doctors and hospitals credit for their roles in the programs; and (f) To counteract unfavorable, often misleading, comparisons already planted in the public mind.

To accomplish these objectives, experts have chosen magazine messages to carry the program in information and education. Other national media, they say, cannot match the initial effect of magazine advertisements which have multi-million readerships, provide uniform effect for all Plans, have long reader-life in homes and offices and, space-wise, are adequate to bring detailed messages to many people.

Local advertising in support of the national program will fit local needs where it did not exist

before. Here in Maryland, where the population is within easy reach of newspaper-radio-television coverage, messages and announcements entirely within the definition of our own not-for-profit, community-service Blue Cross and Blue Shield Plans will be used to back the national effort. Without such local support, the effects achieved nationally might be dissipated before they had much value locally.

There is general agreement that the real intent behind Blue Cross and Blue Shield would not be fulfilled if only a minority, consisting of the more alert or fortunate families, come under the programs. The fundamental concept now, as always, is to provide community-wide protection, not just for the best risks, but for as many people as possible within the areas served by the Plans. National advertising, a fast, sure, and inexpensive way to accomplish our common objectives, is just another approach to this one basic obligation.

ALL OBLIGATED PHYSICIANS DUE FOR ACTIVE SERVICE BY JULY 1, 1955

The AMA Washington Letter, No. 60

During the next fiscal year, starting next July 1, the Defense Department expects that all hospital interns and residents obligated for military service will have to be called to active duty. However, according to Assistant Secretary Berry, the demand may not be as heavy during the first half of the period, due to a backlog of 1953 medical school graduates and a small number left over from Priority I. For the men facing almost inevitable calls, Dr. Berry urges hospitals to make short-term arrangements so they "will have a means of livelihood and also the opportunity to continue their education, as well as to contribute to the needs of the hospitals," while awaiting orders the last six months of this year and the first six months of next.

National Advisory Committee to Selective Service advises that after July 1, 1955, all physicians with military obligations should obtain commissions during their internships. This will remove them from the jurisdiction of their draft boards, and allow Defense Department to request delay in call for men the Department recommends for additional training.

This information is contained in a statement from Dr. Berry, in charge of medical and health matters for the Department of Defense. Dr. Berry also presented the results of a poll of medical school deans, who were requested to ask fourth year students the following questions: (1) If given free choice, which service would you prefer? (2) Do you prefer to serve your time immediately following internship? (3) Or following internship and one year of hospital training? (4) Or following full residency training? The results showed 27% of the students preferred the Army, 37% the Navy and 36% the Air Force. 39% preferred service immediately following internship, 15% preferred it after two years of hospital training and 46% preferred military duty after full residency training.



Woman's Auxiliary Medical and Chirurgical Faculty



MRS. JOHN G. BALL, *Auxiliary Editor*

MONTGOMERY COUNTY CELEBRATES DOCTOR'S DAY



Mrs. Emil G. Bauersfeld

Dr. Austin B. Rohrbaugh

Mrs. Norman Shoemaker

The above photograph shows Dr. Rohrbaugh, President of the Montgomery County Medical Society, being pinned with the official red carnation by Mrs. Norman Shoemaker, Doctor's Day Chairman. Mrs. Emil G. Bauersfeld, President of the Woman's Auxiliary to the Montgomery County Medical Society, takes part in the ceremony which was held on March 30, 1954.

DOCTOR'S DAY, MARCH 30, 1954

In those counties in Maryland in which Woman's Auxiliary to the County Medical Society is organized, doctors were seen wearing red carnations, the official flower, in honor of Doctor's Day. In many hospitals, arrangements of red carnations were placed in memory of deceased doctors.

In some of the counties, doctors were honored by special parties in addition to the carnation bou-tonnieres.

In Washington County, the student nurses at the Washington County General Hospital honored the doctors and their wives at a banquet, March 28th, which was a wonderful success.

In Baltimore County, on March 29th, a Dinner-Dance was held at the Lord Baltimore Hotel and was a most enjoyable affair.

In Prince George's County, on March 30th, a buffet-luncheon was held in Prince George's Hospital. Many radio stations in the State carried spot announcements or even special talks on Doctor's Day.

We are in hopes that people will stop and think a minute about the doctor they usually think of only when they are sick. We would have the citizens of Maryland pause this one day by Governor's Proclamation, to honor the men and women who work every day in the year for the benefit of humanity.

FUTURE NURSES CONVENTION

May 1, 1954

Early in April, invitations were sent to all Senior High Schools in the state of Maryland, inviting any junior or senior high school girls who were interested in nursing to attend our Future Nurses Convention. Girls from many counties attended. They were most enthusiastic and attentive to the day-long program. The program following was their guide for the day.

One of the high points of the day was the Parade of Student Nurses. The girls were eager to see just how they might look if they should attend one particular school. The becoming caps seemed to be the focal point of the uniform. Since they were all wearing Future Nurse paper caps, they had their first "feel" of being "capped." The following hospitals sent Student Nurses to the Convention: St. Joseph's Hospital; Bon Secours Hospital; St. Agnes Hospital; Sinai Hospital; Church Home and Hospital; Mercy Hospital; Lutheran Hospital; Franklin Square Hospital; Provident Hospital; Johns Hopkins Hospital; Woman's Hospital; Maryland General Hospital; University Hospital; Union Memorial Hospital.

The Future Nurses Club delegates were very interested in just what other clubs did and how big they were. This part of the program was for the girls themselves and they really took over.

As a fitting close to an inspiring day, the Maryland Nurse Recruitment Film, "The Girl with the Lamp," was shown.

Among our guests for the day were: Mrs. Harold Johnson, National Nurse Recruitment Chairman; Dr. Samuel McLanahan, Adviser to Woman's Auxiliary; Miss Elizabeth Hagarty, President of the Student Nurses Council of Maryland; Representatives of the Maryland League for Nursing and Maryland State Nurses Association.

Mrs. Harold Johnson, National Nurse Recruitment Chairman was very enthusiastic about our Convention. She felt it was very worthwhile and was happy that she had the opportunity to see it first-hand.

The following pamphlets were given to the girls to help them in deciding which nursing course best suited their abilities: "Team Mates," a folder on practical and professional nursing; "Nursing has a Future for You;" "There is an Exciting Future for you in Public Health Nursing."

As an outgrowth of the Future Nurse Clubs delegates' meeting, at the Future Nurses Convention May 1st, the girls appointed Miss Gay Kaiser, Carroll County, as temporary chairman, to form a State Future Nurses Club organization. Miss Joyce Wheeler, Baltimore County, chairman of constitution and by-laws. Sample constitutions were furnished by Mrs. Harold Johnson, National Nurse Recruitment Chairman. An organization meeting was held at the Medical and Chirurgical Faculty Building on May 15th, under the auspices of the State Auxiliary.

Future Nurses Convention Program

Second Convention

FUTURE NURSES OF MARYLAND

Saturday, May 1, 1954

Towson High School

Cedar Avenue, Towson, Maryland

Sponsored by: Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland, Mrs. Albert E. Goldstein, President, presiding

9:45-10:00 Registration; Girls get Future Nurse caps to wear during convention

10:00-10:05 Lighting of Nightingale Lamps by nurses in uniform

Invocation, Reverend Mr. Bennett Sims

10:05-10:30 "The History of Nursing", A. Stuart Chalfant, M.D.

10:30-10:50 Panel on Courses (5 minutes each)

1. Diploma, Miss Eileen McCoy, R.N.

2. Collegiate, Sister Josephine Cavanaugh, R.N.

3. Practical, Mr. Herbert Johnson, President, Practical Nurses Association
 4. Examination for State Board of Nursing License, Mrs. Bessie Parr, R.N.
- 10:50-11:00 Panel Questions
- 11:00-11:40 Panel on After Graduation (5 minutes each)
1. Private Duty, Mrs. Hortense Tegler, R.N.
 2. General Duty, Mrs. Norma Miller, R.N.
 3. Public Health, Mrs. Eileen Troop, R.N.
 4. Institutional, Miss Louise Hohener, R.N.
 5. Educational Administrators, Consultants and Teachers, Sister Mary Florence, R.N.
 6. Industrial, Miss Margaret Kramer, R.N.
 7. Army Service, Captain Helen Ely, A.N.C.
 8. Special Groups, Miss Dorothy P. Metzler, R.N.
- 11:40-12:15 Panel Questions
- 12:15- 1:00 Lunch (Girls bring own lunch; drink furnished)
- 1:00- 1:45 Parade of Student Nurses, Baltimore Hospitals
- 1:45- 2:00 Baltimore Student Nurse of the Year will speak. Student Nurse to be chosen at Medical and Chirurgical Faculty Ball from candidates from all nursing schools in Baltimore
- 2:00- 2:30 Future Nurses Clubs. Each club has a delegate
- 2:30- 3:00 Film: "Girl with the Lamp" Courtesy Woman's Auxiliary to the Baltimore City Medical Society and Maryland Society for Medical Research, Inc.

Committee:

Nurse Recruitment Chairman: Mrs. James Kerr
 Arrangements: Mrs. D. D. Caples, Mrs. Thomas Webster,
 Mrs. John G. Ball
 Publicity: Mrs. Charles H. Williams

NEWS NOTE

Woman's Auxiliary Produces Film For Nurse Recruitment

The Woman's Auxiliary to the Baltimore City Medical Society, with the aid of the Maryland Society for Medical Research, Inc., and the teaching hospitals of Maryland, has produced a film for Nurse Recruitment entitled, "The Girl with the Lamp." It is a 16 mm. color film with sound, that runs for twenty minutes. This film is available without charge, as a public service of the Auxiliary, for showing in Junior and Senior High Schools, before parent and teachers' groups, civic, women's or church groups, and to religious and community young people's associations.

The film shows not only what a student nurse will actually study, but how she will live and some of the lighter moments of student life. It was made

with the advice of the Maryland State Nurses Association.

Your organization can obtain the picture showing from the Woman's Auxiliary to the Baltimore City Medical Society, Committee on Motion Pictures, 1211 Cathedral Street, Baltimore 1 Maryland.

NATIONAL CONVENTION, SAN FRANCISCO, CALIFORNIA

The thirty-first annual convention of the Woman's Auxiliary to the American Medical Association will be held in San Francisco, California, June 21 to 25, 1954. Headquarters will be at the Hotel Fairmont.

The following Auxiliary members from Maryland are planning to be there: Mrs. George H. Yeager, National Constitutional Secretary; Mrs. A. E. Goldstein, President; Mrs. James Kerr, Nurse Recruitment Chairman; Mrs. Gerald LeVan, President-Elect; Mrs. Bender B. Kneisley; Mrs. J. W. Bird; Mrs. H. T. Morse.

SUMMER READING

Some of us may have more time to read in the summer than during the busy winter months, so here is a list of medically slanted (for the greater part) books.

Fiction

- "The Doctors"—André Soubiran (Medical life in Paris)
 "Not as a Stranger"—Morton Thompson (The making of a doctor)
 "God and My Country"—MacKinley Kantor (For anyone who has a boy or Boy Scout)

Non-fiction

- "Autumn of Liberty"—Paul Harvey (Posing a great question)
 "An Alcoholic to His Sons"—as told to Henry Beetle Hough
 "The Great Medical Bibliographers"—John F. Fulton (interesting men themselves)
 "The Motion of the Heart"—Blake Cabot, M.D. (For the layman)
 "The Allergic Child"—Harry Swartz, M.D. (Primarily for parents with this problem)

COMING MEETINGS

TAKE NOTE!

SEMIANNUAL MEETING OF THE MEDICAL AND CHIRURGICAL FACULTY

⇨ October 14, 1954 ⇩

Hagerstown, Washington County, Maryland

Watch for more details regarding this program, but mark the date on your calendar, so that you will be "among those present."

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SIXTH CONGRESS ON OBSTETRICS AND GYNECOLOGY SET FOR DECEMBER 13-17

The sixth American Congress on Obstetrics and Gynecology will be held at the Palmer House, Chicago, December 13-17, 1954.

The five-day meeting is sponsored by the American Committee on Maternal Welfare, Inc., and the American Academy of Obstetrics and Gynecology. It will bring together the four major groups concerned in the provision of better care for mothers and babies—medicine, nursing, public health and hospital administration.

The program will include twenty-seven formal papers, twenty-two symposia and panels, luncheon discussion groups, and several hundred round-table discussions, covering every phase of maternal and newborn care. Scientific and technical exhibits are also being planned.

Information about the meeting may be obtained by writing to the Sixth American Congress on Obstetrics and Gynecology, 116 South Michigan Avenue, Chicago 3, Illinois.

YOUR JOURNAL!

Publication of the MARYLAND STATE MEDICAL JOURNAL represents less cost to the membership than when a BULLETIN and NEWS LETTER were published. The cost of the Faculty Transactions, which are now current, is absorbed by the JOURNAL. Formerly they were published on an accumulation basis of five to ten years.

A.M.A. NEWS RELEASE—WASHINGTON OFFICE

May 7—1954

Washington, D. C.—At the request of the Defense Department, Congress is considering a bill to expand and make more uniform the medical care program for civilian dependents of military personnel. It could have significant impact on the practice of medicine and on medical economics.

The legislation developed out of the Defense Department's Moulton Commission report of a year ago. In the intervening months the department's legislative planners called in representatives of the American Medical Association and other professional groups for advice. But the bill finally presented to Congress is evidence that not all differences of opinion were compromised. While in many respects the measure is in line with the policy of AMA on dependent care, at least one basic conflict remains:

The department's bill states that dependents should receive private medical care only when military facilities are unavailable or inadequate. The AMA's policy, adopted after long study of the problem, is that dependents should be cared for in military hospitals and by uniformed physicians only when civilian care is inadequate or unavailable.

There is almost complete agreement that the present patchwork dependent medical care program should be changed to make benefits uniform geographically and within the services, and to spell out the benefits in law. The issue is whether the military medical services should care for all qualified civilian dependents, or dependents should, like the rest of the population, get their medical care from civilian physicians and hospitals.

Under the bill, medical care furnished by or underwritten by the federal government would be limited to "diagnosis, acute medical and surgical conditions, contagious diseases, immunization, and maternity and infant care." Dental care would be allowed only in emergencies or as an adjunct to medical care. These restrictions would be waived overseas and at remote stations in the United States.

The definition of "dependents" would not extend beyond parents and parents-in-law, and these relatives would have to receive at least half their support from the military member to qualify.

The Secretary of Defense would decide what charges, if any, to levy against dependents treated at military facilities. When treated privately, the dependents would pay the first \$10 cost of any illness, plus not more than 10% of the total cost. The secretary could make use of voluntary health insurance for dependents if this system were found to be more economical.

The Senate Armed Services Committee was slow to take up the dependent care bill because of a heavy schedule of other hearings. Nor did it make fast progress in the House. There the introduction of the bill was delayed when Chairman Dewey Short (R., Mo.) called on Defense Department to furnish him with detailed information on what the new medical care program would cost.

By mid-May, when Congress had about concluded hearings on all major administration health bills, a new factor was introduced. Chairman Wolverton of the House Interstate and Foreign Commerce Committee called hearings on his own bill for federal guarantee of private loans to health facilities. This was not part of the original Eisenhower health program, but there were some indications that the administration might get behind it.

As originally drawn, the bill would virtually exclude all clinics and hospitals except those operated in conjunction with prepaid insurance plans. During the hearings, Mr. Wolverton indicated he would be willing to drop this restriction. If this were done, the law then would offer benefits to all—fee-for-service physicians and groups as well as "closed panels."

During this period, some sentiment developed to combine the loan guarantee bill with the reinsurance bill, which wasn't making much progress on its own. The result was a period of

confusion and uncertainty, with no clear indication of what either the committee or the administration really wanted.

A few other medically-important bills were advancing on schedule. The House Ways and Means Committee gave every indication of reporting out a bill to require all employers (physicians included) to participate in the federal-state unemployment insurance program. As usual moving faster than the Senate, the House had passed a bill to give state health officers more control over federal grants for public health work. The House also was nearing a vote on extension of the social security program, with no suggestion that physicians and other self-employed groups who don't want coverage would be exempted. The House-approved Hill-Burton expansion bill was waiting action in the Senate.

MANION COMMISSION STARTS SURVEY OF GRANTS IN FIVE STATES

A. M. A. Washington Letter, No. 58

On contract from the Commission on Intergovernmental Relations, private research organizations have started a study of five states "widely representative of the national picture" to determine the impact of federal aid programs on state and local governments. The states are Kansas, Wyoming, Michigan, Mississippi, and Washington. Twenty-two federal grant programs representing 87% of the nearly \$3 billion spent annually for all federal aid, will be investigated. Included will be hospital construction, general public health, venereal disease, tuberculosis, mental health, cancer, heart disease, and housing and slum clearance. The commission explains: "The surveys are expected to enable the commission to recommend what functions, if any, should be reallocated as between the federal, state, and local governments, and what modifications of existing procedures in the federal aid programs are necessary to eliminate overlapping, unnecessary controls and excessive costs."

The law creating the commission specified that its report was to be made to the President by March 1, but this is now impossible. At that time some findings will be available for release, a spokesman for the commission said, but it has not been decided whether this information will be made public piecemeal, or held until a more complete report can be compiled. The five-state study is to be completed in 90 days.

A. M. A. Washington Letter, No. 58

A Veterans Administration report estimates that since 1944 some 180,000 veterans have studied medicine or related courses under the GI bill of rights; about 300,000 veterans are still in training under the broad program which expires in 1956. . . . An Office of Defense Mobilization manpower study states that in event of full mobilization greatest personnel shortages would occur in health, scientific and technical fields; raising the nation's physical and mental level is perhaps the greatest potential addition to military manpower resources, the report adds. . . Atomic Energy Commission has announced in its semiannual report to Congress the completion at Los Alamos, N. Mex., of the only health laboratory exclusively for research in hazard aspects of atomic weapon development. . . Brig. Gen. Alvin L. Gorby, senior medical advisor to the Assistant Secretary of Defense (health and medical), has been appointed deputy commander of Walter Reed Army Medical Center . . . Effective July 1, Army Medical Service residency program in anesthesiology will be increased from two to three years . . . V. A. reports an urgent need for social workers, dietitians, biochemists, X-ray and medical technicians, and therapists for V. A. hospitals.

VACANCY

It is anticipated that there will be several vacancies on the residency staff in Internal Medicine at the VA Hospital, Fort Howard, Maryland, commencing July 1, 1954. Interested physicians are requested to communicate with Dr. Francis G. Dickey, Chief of Medicine, at the Veterans Hospital.

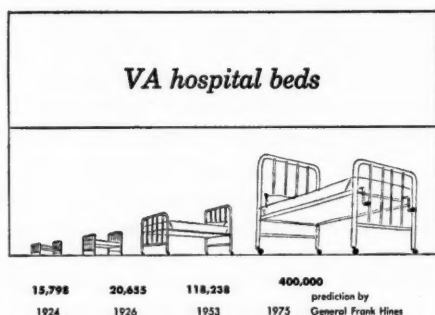
"MUST WE FOLLOW THE VA ROUTE TO SOCIALIZED MEDICINE?"

Have you read this article which appeared in the March issue of the Reader's Digest? It is an independent view of the facts upon which the House of Delegates of the American Medical Association has based its adopted policy on the VA medical care program.

Dr. Ralph G. Hills, the Chairman of the Medical and Chirurgical Faculty's Committee on Veterans' Medical Care, urges every physician to read the article, and also advises that reprints be placed in your offices so that your patients may be informed regarding this subject.

Reprints may be obtained by writing to Dr. Louis M. Orr, Council on Medical Service, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

In Viewing the VA Medical Program . . .



Former VA Administrator Frank Hines estimated that by 1975 under existing VA medical legislation, approximately 400,000 hospital beds will be needed. Yet medical authorities are convinced the VA cannot attract sufficient medical personnel to staff more than 120,000 beds. The VA now maintains three times the number of beds needed for treatment of service-connected cases.

In Viewing the VA Medical Program . . .

average length of stay in VA hospital			
	Average (days)	World War II (days)	World War I & Other (days)
TB	205.8	203.6	210.2
NP	178.3	89.2	430.6
GMS	30.8	23.5	42.5

The average length of stay in VA hospitals for World War I veterans is considerably greater than for World War II veterans, which now comprise 76% of the total veteran population. The greatest pressure is yet to be exerted on VA hospitals as World War II veterans grow older and require increased medical care for disabilities unrelated to military service.